Doral™
A DentaQuest Ventures Company

Smiles For Children℠
Improving Dental Care Across Virginia

Doral Dental USA, LLC

Smiles For Children

Commonwealth of Virginia Medicaid, FAMIS, FAMIS Plus, Dental Program

Office Reference Manual

12121 N. Corporate Parkway
Mequon, WI 53092
888.912.3456
www.doralusa.com

Doral Dental USA, LLC
Address and Telephone Numbers

Provider Services
12121 N. Corporate Parkway
Mequon, WI 53092

***Smiles For Children*: 888.912.3456**

Network Development
Fax numbers:
Claims/payment issues: 262.241.7379
Claims to be processed: 262.834.3589
All other: 262.834.3450
Claims questions:
denclaims@doralusa.com
Eligibility or Benefit Questions:
denelig.benefits@doralusa.com

Credentialing
12121 N. Corporate Parkway
Mequon, WI 53092
Fax: 262.241.4077

Customer Service/Member Services
12121 N. Corporate Parkway
Mequon, WI 53092
888.912.3456

TDD (Hearing Impaired)
800.466.7566

Special Needs Member Services
800.660.3397

Fraud Hotline
800.237.9139

Doral's Virginia Office
Doral Dental USA, LLC
4860 Cox Road, Suite 247
Glen Allen, VA 23060
800.519.1321

Prior authorizations for Hospital Operating Room Cases should be sent to:
Doral Dental USA, LLC-OR Authorizations
P.O. Box 339
Mequon, WI 53092

Authorizations should be sent to:
Doral Dental USA, LLC–VA Authorizations
12121 N. Corporate Parkway
Mequon, WI 53092

Dental claims should be mailed to:
Doral Dental USA, LLC-VA Claims
12121 N. Corporate Parkway
Mequon, WI 53092
or e-mailed to:
operations@doralusa.com

Electronic Claims should be sent:
Via the web - www.doralusa.com
Via Clearinghouse
Doral Systems Corporation
12121 N. Corporate Parkway
Mequon, WI 53092

Provider Appeals should be sent to:
Doral Dental USA, LLC
Utilization Management/Provider Appeals
12121 N. Corporate Parkway
Mequon, WI 53092

Member Grievance and Appeals
888.912.3456
Doral Dental USA, LLC
Smiles For Children
Complaints and Appeals
12121 N. Corporate Parkway
Mequon, WI 53092

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SMILES FOR CHILDREN

Statement of Members Rights and Responsibilities

The mission of ***Smiles For Children*** is to expand access to high-quality, compassionate oral health services within the allocated resources. ***Smiles For Children*** is committed to ensuring that all Members are treated in a manner that respects their rights and acknowledges its expectations of Member's responsibilities. The following is a statement of Member's rights and responsibilities.

1. All Members have a right to receive pertinent written and up-to-date information about ***Smiles For Children***, the services ***Smiles For Children*** provides, the Participating Providers and dental offices, as well as Member rights and responsibilities.

2. All Members have a right to privacy and to be treated with respect and recognition of their dignity when receiving dental care.

3. All Members have the right to fully participate with caregivers in the decision making process surrounding their health care.

4. All Members have the right to be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed. Members also have the right to request a second opinion.

5. All Members have the right to voice a complaint against ***Smiles For Children,*** or any of its participating dental providers, or any of the care provided by these groups or people, when their performance has not met the Member's expectations.

6. All Members have the right to appeal any decisions related to patient care and treatment. Members may appeal directly to Doral or to the Department of Medical Assistance Services (DMAS).

7. All Members have the right to make recommendations regarding ***Smiles For Children*****'s** members' rights and responsibilities policies.

Likewise:

1. All Members have the responsibility to provide, to the best of their abilities, accurate information that ***Smiles For Children*** and its participating dentists need in order to receive the highest quality of health care services.

2. All Members have a responsibility to closely follow the treatment plans and instructions for the care that they have agreed upon with their dental practitioners.

3. All Members, have the responsibility to make every effort to keep dental appointments.

4. All Members have the responsibility to participate in understanding their dental problems and developing mutually agreed upon treatment goals to the degree possible.

Smiles For Children

Statement of Provider Rights and Responsibilities

Providers shall have the right to:

1. Communicate with patients, including Members regarding dental treatment options.

2. Recommend a course of treatment to a Member, even if the course of treatment is not a covered benefit, or approved by the ***Smiles For Children*** program.

3. File an appeal or complaint pursuant to the procedures of ***Smiles For Children***.

4. Supply accurate, relevant, and factual information to any Member in connection with an appeal or complaint filed by the Member.

5. Object to policies, procedures, or decisions made by ***Smiles For Children.***

6. Charge an eligible ***Smiles For Children*** Member for dental services that are not covered services only if the Member knowingly elects to receive the services as a private-pay patient and enters into an agreement in writing to pay for such services prior to receiving them. Non-covered services include: services not covered under the ***Smiles For Children*** plan; services for which pre-authorization has been denied and deemed not medically necessary; and services which are provided out-of-network.

7. Be informed timely of the status of their credentialing or recredentialing application, upon request.

8. To determine to what extent they will participate in the ***Smiles For Children*** program (i.e. set patient panel size).

Providers have the responsibility to:

1. Protect the patients'/members' rights to privacy.

2. Notify Doral of any changes in their practice information, including: location, telephone number, limits to participation, providers joining or leaving the practice, etc.

3. Hold the ***Smiles for Children*** Members harmless and shall not bill any Member for services if the services are not covered as a result of any error or omission by Provider.

4. Adhere to the ***Smiles for Children*** Provider Participation Agreement.

* * *

Doral makes every effort to maintain accurate information in this manual; however, Doral will not be held liable for any damages directly or indirectly due to typographical errors. Please contact us should you discover an error.

Office Reference Manual
Table of Contents

1.00 What is *Smiles For Children*?

Smiles For Children is the new dental program for children enrolled in Medicaid, FAMIS or FAMIS Plus. All dental services for Medicaid, FAMIS or FAMIS Plus Members will be provided through ***Smiles For Children***. ***Smiles For Children*** is provided by the Commonwealth of Virginia's Department of Medical Assistance Services (DMAS) in collaboration with the Virginia Dental Association (VDA) and the Old Dominion Dental Society (ODDS) and is administered by Doral Dental USA, LLC on an administrative services only (ASO) basis. This means that Doral will process and pay claims to providers on a fee-for-service basis, based on the ***Smiles For Children*** fee schedule, and DMAS retains responsibility for reimbursement to Doral for the cost of the claim payments made to providers. Reimbursement to providers outside of the ***Smiles For Children*** network is not available.

Smiles For Children provides coverage for Medicaid and FAMIS Plus children under 21 years of age and under age 19 for FAMIS children. Covered services are defined as any medically necessary diagnostic, preventive, restorative, and surgical procedures, as well as orthodontic procedures, administered by, or under the direct supervision of, a dentist. Limited medically necessary oral surgery coverage is available for enrollees 21 years of age and older when performed by a participating dentist and only when the service is one that is either generally covered under Medicare and/or is medically necessary. Examples of medically related covered services for adults include removal of cysts and tumors not related to the teeth, biopsies for suspected malignancies, repair of traumatic wounds, and extraction of teeth for severe abscesses complicating a medical condition or contributing to poor general health. Reference Exhibits A and B of this manual for detailed coverage criteria and guidelines.

The goals of the ***Smiles For Children*** program are to:

- Increase provider participation in the ***Smiles For Children*** network
- Streamline program administration, making it easier for provider to participate
- Create a partnership between DMAS, Doral and Organized Dentistry
- Improve Member access to quality dental care
- Improve oral health and wellness for Virginia's children

Value-Added Provider Benefits

1.01 Dedicated Call Center for Providers

Doral offers Participating ***Smiles For Children*** Providers access to call center representatives who specialize in areas such as:

- Eligibility, benefits and authorizations,
- Member placements, and
- Claims

You can reach these specialists by calling 888.912.3456.

1.02 Provider Training

Doral offers free Provider training sessions periodically throughout the Commonwealth of Virginia. These sessions include important information such as: claims submission procedures, pre-payment and prior-authorization criteria, how to access Doral's clinical personnel, etc. In addition, Providers can contact the Virginia Provider Relations Representative for assistance, or to request a personal, in-office visit, by calling: 804.217.8392. or 800.519.1321.

1.03 Provider Newsletters

Doral publishes quarterly Participating Provider newsletters that include helpful information of interest to providers. To request a copy of the Doral provider newsletter, you may call our Virginia Provider Relations Representative at 804.217.8392, or call 888.912.3456.

1.04 Doral Website

Doral's website includes a "For Provider's Only" section, that allows Participating ***Smiles For Children*** Providers access to several helpful options including:

- Member eligibility verification
- Claims submission
- Authorization Submission
- View claim status
- Create claim tracking reports
- Member treatment history

For more information, contact Doral's Systems Operations Department at 888.560.8135 or via email to operations@doralusa.com.

1.05 Other Value-Added Provider Benefits

Other value-added provider benefits (detailed in other sections of this manual) include:

- Dedicated Virginia Project Director, Provider Relations Representative, Outreach Coordinator, and Dental Director
- Streamlined Credentialing
- Minimal Prior Authorization Requirements

2.00 Patient Eligibility Verification Procedures

2.01 *Smiles for Children* Eligibility

Any eligible Medicaid, FAMIS or FAMIS Plus person is eligible for dental benefits under the ***Smiles For Children*** Program. Please note that when calling DMAS to verify member eligibility, members indicated as enrolled ONLY in the Family Planning Waiver Program (Aid Category 80) are not eligible for dental benefits under the ***Smiles for Children*** Program. Dental providers must call Doral to verify member eligibility. Recipients will not receive a separate ***Smiles For Children*** ID card for dental services. Medicaid, FAMIS and FAMIS Plus eligible recipients will receive dental coverage under ***Smiles For Children*** regardless of their MCO enrollment status. Therefore, recipients may use their Commonwealth of Virginia (blue and white) plastic identification card or any of the following MCO cards: Virginia Premier Health Plan, Optima Family Care, CareNet by Southern Health, AMERIGROUP (as of September 1, 2005), Anthem HealthKeepers Plus, Anthem HealthKeepers Plus by Peninsula, and Anthem HealthKeepers Plus by Priority. (*Although dental services have been carved out from the MCO contracts, all MCO ID cards list the 12-digit Medicaid, FAMIS, and FAMIS Plus ID number for eligibility verification purposes.)*

2.02 Doral Eligibility Systems

Participating ***Smiles For Children*** Providers may access Member eligibility information through Doral's Interactive Voice Response (IVR) system or through the "Providers Only" section of Doral's website at www.doralusa.com. The eligibility information received from either system will be the same information you would receive by calling Doral's Customer Service department; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Customer Service Representative.

Access to eligibility information via the Internet:
Doral's Internet currently allows Providers to verify a Member's eligibility as well as submit claims directly to Doral. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service and the Member's identification number or last name and first initial. To access the eligibility information via Doral's website, simply log on to the website at www.doralusa.com. Once you have entered the website, click on "Doral Dental USA" and then click on "For Providers Only." You will then be able to log in using your password and ID.

First Time Users:
First time users will have to register by utilizing their 6 digit Doral Location ID, office name and office address. Please refer to your payment remittance or contact Doral's Systems Operations Department at 888.560.8135 or via email to operations@doralusa.com to obtain your location ID You may contact Doral's Systems Operations Department staff between 8 AM and 6 PM Monday through Friday. Once logged in, select "eligibility look up" and enter the applicable information for each Member you are inquiring about. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

Access to eligibility information via the Interactive Voice Response IVR line:
To access the IVR, simply call Doral's Customer Service department at 888.912.3456 and press 1 for eligibility. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Customer Service Representative to answer any additional questions, i.e. Member history, which you may have. Using your telephone keypad, you can request eligibility information on a ***Smiles For Children*** Member by entering your 6 digit Doral location number, the Member's recipient identification number and an expected date of service. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the Member information you entered, you will be transferred to a Customer Service Representative.

Directions for using Doral's IVR to verify eligibility:
Entering system with Tax and Location ID's

1. Call Doral Customer Service at 888.912..3456.
2. After the greeting, stay on the line for English or press 1 for Spanish.
3. When prompted, press or say 2 for Eligibility.
4. When Prompted, press or say 1 to enter your 6-digit **Doral Location ID** and the last 4 digits of your **Tax ID number**.
5. Does the member's ID have **numbers and letters** in it? If so, press or say 1. When prompted, enter the member ID.
6. Does the member's ID have **only numbers** in it? If so, press or say 2. When prompted, enter the member ID.
7. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another member, get benefit information, get limited claim history on this member, or get fax confirmation of this call.
8. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.
9. If you choose to make a claim inquiry, you will be transferred to a Customer Service Representative.

Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment.

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at 888.912.3456. They will be able to assist you in utilizing either system.

2.03 Commonwealth of Virginia DMAS Eligibility System

DMAS offers a web-based Internet option (automated response system - ARS) to access information regarding Medicaid and FAMIS eligibility. The website address to use to enroll for access to this system is http://virginia.fhsc.com. Providers may also utilize the DMAS MediCall voice response system for eligibility verification and can be accessed by calling 800-884-9730 or 800-772-9996. Both options are available at no cost to the provider. Providers are encouraged to first verify an enrollee's eligibility by using Doral's eligibility systems.

2.04 Specialist Referral Process

A patient requiring a referral to a dental specialist can be referred directly to any specialist participating in the ***Smiles For Children*** program without authorization from Doral. The dental specialist is responsible for obtaining prior authorization if necessary, for services according to Exhibits A and B of this manual. If you are unfamiliar with the Doral contracted specialty network or need assistance locating a certain specialty, please contact Doral's Customer Service Department at the telephone number found on page 2 of this manual.

2.05 Provider Directory

Doral publishes a provider directory to ***Smiles For Children*** Members. The directory is updated periodically and includes: provider name, practice name (if applicable), office addresses(s), telephone number(s), provider specialty, panel status (for example, providers limiting their practice to existing patients only), office hours (if available), and any other panel limitations that Doral is aware of, such as patient age minimum and maximum, etc.

It is very important that you notify Doral of any change in your practice information. Please complete the Provider Change Form found on page A-15, fax it to Doral at 262.241.7366, or call us at 888.912.3456 to report any changes.

2.06 Member Transportation

Transportation may be available for ***Smiles For Children*** Members through their MCO or through DMAS if the member is not enrolled in a MCO. Doral will refer ***Smiles For Children*** Members to the appropriate transportation vendor for assistance. ***Smiles For Children*** Member transportation assistance can be arranged by calling the following numbers:

- Members in Fee For Service, AMERIGROUP, Anthem — 866.386.8331
- Members in CareNet — 800.734.0430
- Members in Optima Family Care — 877.892.3986
- Members in Virginia Premier — 800.727.7536 (Central)
  800.828.7989 (Tidewater)
  888.338.4579 (Roanoke)

2.07 Broken Appointments

Broken appointments are a major concern for the Department of Medical Assistance Services, the Virginia Dental Association, the Old Dominion Dental Society, and Doral. We recognize that broken appointments are a costly and unnecessary expense for providers. Our goal is to remove any barriers that prevent dentists from participating in the ***Smiles For Children*** program as well as barriers that prevent our members from utilizing their benefits. In order to accurately identify and address the barriers, we need to better track, trend, and understand the issue. Therefore, the Broken Appointment Log was developed and implemented.

The Broken Appointment Log is a form that captures data regarding a member's missed appointments. Doral is requesting you complete and submit the log to help us identify the members who may need additional assistance. Broken Appointments are defined as those appointments that are not rescheduled or cancelled in accordance with your office

policies. Doral will use your reported information to educate families regarding the importance of keeping appointments and maintaining compliance with treatment plans. Simply complete the form (page A-18) and fax it to Kristen Fincher, Doral's Virginia Outreach Coordinator at 804-217-8350. A copy of this form may be downloaded from the DMAS website at http://www.dmas.virginia.gov or you can obtain a copy of the form by contacting Kristen Fincher at 1-800-519-1321.

3.00 Authorization for Treatment

3.01 Dental Treatment Requiring Authorization

Under ***Smiles For Children***, the number of services requiring prior authorization or pre-payment review is significantly reduced. Authorization is a utilization tool that requires Participating ***Smiles For Children*** Providers to submit "documentation" associated with certain dental services for a Member. Participating Providers will not be paid if this "documentation" is not furnished to Doral. Participating Providers must hold the Member, Doral, and DMAS harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization (either before or after service is rendered).

Doral utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. Doral's operational focus is to assure compliance with its utilization criteria. The criteria are included in this manual (see Clinical Criteria section 14.00). Please review these criteria as well as the Benefits covered to understand the decision making process used to determine payment for services rendered.

A. Authorization and documentation submitted before treatment begins. (Prior Authorization) and Documentation submitted with claim (Pre-payment Review).

Services that require prior-authorization should not be started prior to the determination of coverage (approval or denial of the authorization). Treatment requiring prior-authorization started prior to the determination of coverage will be performed at the financial risk of the dental office.

Services that require pre-payment review, but not prior authorization will require proper documentation prior to consideration for payment. The dentist also has the option of requesting prior authorization (instead of pre-payment review) if a ***Smiles For Children*** decision regarding coverage is desired prior to rendering treatment services.

Your submission of "documentation" should include:

1. Radiographs, narrative, or other information where requested (See Exhibit A and B for specifics by code)
2. CDT codes on the claim form

Your submission should be sent on an ADA approved claim form. The tables of Covered Services (Exhibit A and B) contain a column marked "Authorization Required". A "Yes" in this column indicates that the service listed requires either prior-authorization or documentation submitted with the claim for pre-payment review in order to be considered for reimbursement. The "Documentation Required" column will describe what information is necessary for review, and whether it must be submitted on a prior-authorization basis, or with a claim following treatment for pre-payment review.

After the Doral dental director reviews the documentation, the submitting office shall be provided an authorization number. The authorization number will be provided within two business days from the date the documentation is received. The authorization number will be issued to the submitting office by mail and must be submitted with the other required claim information after the treatment is rendered. (For prior authorization only)

3.02 Authorization for Operating Room (OR) Cases

All operating room (OR) cases must be prior-authorized. The Participating ***Smiles For Children*** Provider should submit the prior authorization to Doral. Doral will serve as the central point of contact for the dental provider, medical facility, medical anesthesiologist, MCO, DMAS and any other required provider. Doral's dental director will review the case for medical necessity, and render an approval or denial of the services. Once Doral has approved the case, Doral will coordinate authorization for non-dental services (example: facility and anesthesia) with DMAS and the MCO as appropriate, within the MCO provider network.

The Participating ***Smiles For Children*** Provider may contact Doral for a list of participating hospitals and facilities.

Please see section 4.08 for information on submitting claims for services performed in a non-dental setting.

3.03 Payment for Non-Covered Services

Participating Providers shall hold Members, Doral, and DMAS harmless for the payment of non-Covered Services except as provided in this paragraph. A provider may charge an eligible ***Smiles For Children*** Member for dental services which are not covered services only if the Member knowingly elects to receive the services and enters into an agreement in writing to pay for such services prior to receiving them. Non-covered services include:

- Services not covered under the ***Smiles For Children*** plan,
- Services for which prior-authorization has been denied and deemed not medically necessary,
- Services which are provided out-of-network

3.04 Electronic Attachments

Doral accepts dental radiographs electronically via **FastAttach™** for prior-authorization requests and pre-payment review. Doral, in conjunction with National Electronic Attachment, LLC (NEA), allows Participating ***Smiles For Children*** Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives and EOBs.

FastAttach™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for FastAttach go to www.nea-fast.com or call NEA at:

800.782.5150

4.00 Claim Submission Procedures (Claim Filing Options)

Doral receives dental claims in four possible formats. These formats include:

- Electronic claims via Doral's website (www.doralusa.com)
- Electronic submission via clearinghouses
- HIPAA Compliant 837D File
- Paper claims

4.01 Electronic Claim Submission Utilizing Doral's Internet Website

Participating ***Smiles For Children*** Providers may submit claims directly to Doral by utilizing the "For Provider's Only" section of our website. Submitting claims via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service. You are also able to create reports to verify claims submission via the Doral website.

To submit claims via the website, simply log on to www.doralusa.com. Once you have entered the website, click on "Doral Dental USA", and then click on "For Providers Only." You will then be able to log in using your password and ID. First time users will have to register by utilizing their Doral 6 digit Location ID prior to logging in. Once logged in, select "enter a claim now" and enter the Member's applicable information in the field provided. It is NOT necessary to enter the Member's last name and/or first initial; only the identification number, date of birth, and date of service are required. Next you will click on the word "before" that appears below the Member's DOB field to verify eligibility and populate the name fields automatically. Once this information is generated you may now begin to enter the claim line detail to complete the submission.

If you have questions on submitting claims or accessing the website, please contact our Systems Operations Department at 888.560.8135 or via e-mail at:

operations@doralusa.com

4.02 Electronic Claim Submission via Clearinghouse

In some markets, Dentists may submit their claims to Doral via Affiliated Network Services (ANS). Doral's current relationship with ANS offers **FREE** transmission for ALL Doral Dental claims. For more information regarding this arrangement, contact ANS at 800.417.6693, extension 234. Additional clearinghouses may be added in the future.

You can contact your software vendor and make certain that they have Doral listed as a payer. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to Doral. Doral's Payer ID is CX014.

4.03 HIPAA Compliant 837D File

For Providers who are unable to submit electronically via the Internet or a clearinghouse, Doral will, on a case by case basis, work with the Provider to receive their claims electronically via a HIPAA Compliant 837D file from the Provider's practice management system. Please contact the Systems Operations Department at 888.560.8135 or via e-mail at operations@doralusa.com to inquire about this option for electronic claim submission**.**

4.04 Paper Claim Submission

- Claims must be submitted on ADA approved claim forms or other forms approved in advance by Doral.

- Member name, identification number, and date of birth must be listed on all claims submitted. If the ***Smiles For Children*** Member identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.

- The Provider and office location information must be clearly identified on the claim. Frequently, if only the dentist signature is used for identification, the dentist's name cannot be clearly identified. Please include either a typed dentist (practice) name or the Doral Provider identification number.

- The date of service must be provided on the claim form for each service line submitted.

- Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services.

- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.

- Affix the proper postage when mailing bulk documentation. Doral does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

Claims should be mailed to the following address:

Doral Dental USA, LLC- VA Claims
12121 N. Corporate Parkway
Mequon, WI 53092

4.05 Coordination of Benefits (COB)

When Doral is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier's payment meets or exceeds a provider's contracted rate or fee schedule, Doral will consider the claim paid in full and no further payment will be made on the claim.

4.06 Filing Limits

The timely filing requirement for the Smiles For Children program is 180 calendar days from the date of service and receipt of claim. Doral determines whether a claim has been filed timely by comparing the date of service to the receipt date applied to the claim when the claim is received. If the span between these two dates exceeds the time limitation, the claim is considered to have not been filed timely.

Resubmissions: Adjustment Claims and Claims for Reconsideration of Payment

Adjustment claims or claims that are resubmitted for reconsideration of payment are handled as follows:

- If the original claim was processed and paid and an adjustment is requested, the adjustment claim must be submitted and received within 12 months from the date the original claim was paid.
- If the original claim was processed and denied and a reconsideration of the denied claim is requested, the denied claim must be resubmitted and received within 12 months from the date the original claim was denied provided that the claim was not initially denied for timely filing. **A claim that is denied for timely filing cannot be appealed.**

Providers cannot bill the member for claims denied for "untimely filing."

Timely Filing and Coordination of Benefits

When a member has other coverage, the timely filing limit begins with the date of payment or denial from the primary carrier.

4.07 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each Participating ***Smiles For Children*** Provider, Doral performs an audit of all claims upon receipt. This audit validates Member eligibility, procedure codes and dentist identifying information. A Doral Benefit Analyst analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Customer Service Department at 888.912.3456 with any questions you may have regarding claim submission or your remittance.

Each Doral Participating ***Smiles For Children*** Provider office receives an "explanation of benefit" report with their remittance. This report includes patient information and the allowable fee for each service rendered.

4.08 Claim Submission and Payment for Operating Room (OR) Cases

Facility and anesthesia services for operating room cases require pre-authorization. Authorization requirements are outlined in Section 2.02

Claims related to the facility and anesthesia services rendered in a non-dental setting will be handled as follows:

A. Managed Care Organization (MCO) Members

1. If the dental provider performs the anesthesia services in a non-dental setting, all dental and anesthesia services should be submitted to and are paid by Doral. In such cases, facility charges should be submitted directly to the MCO.

2. If the dental provider does not perform the anesthesia services for dental services provided in a non-dental setting, the dental services should be submitted to and are paid by Doral. In such cases, both facility and anesthesia charges should be billed directly to the MCO and within the MCO provider network.

B. Fee For Service (FFS) Members

1. For Medicaid/FAMIS Plus and FAMIS eligible individuals who are not enrolled in an MCO on the date of service (served by the FFS program), facility, anesthesia and any required medical providers must participate in the FFS Medicaid program. If the dental provider performs the anesthesia services in a non-dental setting, all dental and anesthesia services should be submitted to and are paid by Doral. In such cases, facility charges should be submitted directly to DMAS.

2. If the dental provider does not perform the anesthesia services for dental services provided in a non-dental setting, the dental services should be submitted to and are paid by Doral. In such cases, both facility and anesthesia charges should be billed directly to DMAS and within the DMAS provider network.

5.00 Health Insurance Portability and Accountability Act (HIPAA)

As a healthcare provider, your office is required to comply with all aspects of the HIPAA regulations that have gone/will go into effect as indicated in the final publications of the various rules covered by HIPAA. The compliance dates for the various HIPAA rules are as follows:

- Privacy Standards – April 14, 2003
- Administrative Simplification Standards – October 16, 2003 (If you filed for the one year extension beyond the initial October 16, 2002 date).
- Security Standards – April 21, 2005

Doral has implemented various operational policies and procedures to ensure that it is compliant with the Privacy Standards as well. Doral also intends to comply with all Administrative Simplification and Security Standards by their compliance dates. One aspect of our compliance plan will be working cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, Doral provider contracts reflect the appropriate HIPAA compliance language. The contracts include the following in regard to record handling and HIPAA requirements:

- Maintenance of adequate dental/medical, financial and administrative records related to covered dental services rendered by Provider in accordance with federal and state law.

- Safeguarding of all information about Members according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through a Provider, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and feral laws.

- Neither Doral nor Provider shall share confidential information with a Member's employer absent the Member's consent for such disclosure.

- Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with Doral in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

Provider and Doral agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT-5) recognized by the ADA. Effective the date of this manual, Doral will require providers to submit all claims with the proper CDT-5 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

Note: Copies of Doral's HIPAA policies are available upon request by contacting Doral's Customer Service Department at 888.912.3456 or via e-mail at denelig.benefits@doralusa.com.

Please see the ANSI Companion Guide (end of Appendix A) for Dental Healthcare Transactions.

6.00 Grievances and Appeals

6.01 Provider Grievances and Appeals

Participating ***Smiles For Children*** Providers that disagree with determinations made by the Doral dental directors may submit a written Notice of Appeal to Doral that specifies the nature and rationale of the disagreement. This notice *and* additional support information must be sent to Doral at the address below within 30 days from the date of the original determination to be reconsidered by Doral's Virginia Peer Review Committee.

Doral Dental USA, LLC
Attention: Utilization Management/Provider Appeals
12121 N. Corporate Parkway
Mequon, WI 53092

All notices received shall be submitted to Doral's Virginia Peer Review Committee for review and reconsideration. The Committee will respond in writing with its decision to the Provider. Upon completion of the Doral appeal process the Participating provider may appeal to the Department of Medical Assistance Services (DMAS). The appeal must be in writing and sent to DMAS within 30 days from the final appeal decision letter from Doral. Appeals to DMAS must be sent to the following address:

Director
Appeals Division
Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219

6.02 Member Grievances and Appeals

Complaints (Grievances)
Members may submit complaints to Doral telephonically or in writing on any Smiles for Children program issue other than decisions that deny, delay, reduce, or terminate dental services. Some examples of complaints include: the quality of care or services received, access to dental care services, provider care and treatment, or administrative issues. Member complaints should be directed to:

Doral Dental USA, LLC
Smiles For Children
Attention: Complaints and Appeals
12121 N. Corporate Parkway
Mequon, WI 53092
1-888-912-3456

Doral will respond to member complaints immediately if possible but within no more than 30 working days from the date the complaint (grievance) is received.

Member Appeals
Members have the right to appeal any adverse decision Doral has made to deny, reduce, delay or terminate dental services. Members may request assistance with filing an appeal by contacting Doral at 1-888-912-3456. Members may send appeal requests to Doral at the address listed above within 30 days receipt of the adverse decision notice. Doral will respond in writing to member appeals within 30 days of the date of receipt, or within 3 days if the condition needs immediate attention.

State of Virginia Fair Hearing Process

Members also have the right to appeal directly to DMAS at the same time, after, or instead of appealing to Doral Dental. Appeal requests to DMAS must be sent in writing and must be sent within 30 days receipt of Doral's adverse decision to:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219
(804) 371-8488
Appeal/review requests may also be faxed to:
(804) 371-8491

Note: Copies of Doral policies and procedures can be requested by contacting Customer Service at 888.912.3456.

7.00 Utilization Management Program

7.01 Introduction

Under the provisions of federal regulations, the ***Smiles For Children*** Program must provide for continuing review and evaluation of the care and services paid through Medicaid and FAMIS, including review of utilization of the services by providers and by recipients. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. ***Smiles For Children*** conducts periodic utilization reviews on all providers . In addition, ***Smiles For Children*** conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals. Participating providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from Doral. Under the ***Smiles For Children*** Participation Agreement the provider also agrees to give access to records and facilities to ***Smiles For Children*** program representatives upon reasonable request. This section provides information on utilization review and control requirement procedures conducted by ***Smiles For Children*** program personnel.

7.02 Community Practice Patterns

In following with the requirements described in Section 7.01 above, Doral has developed a philosophy of Utilization Management that recognizes the fact that there exists, as in all healthcare services, a relationship between the dentist's treatment planning, treatment costs and treatment outcomes. The dynamics of these relationships, in any region, are reflected by the "community practice patterns" of local dentists and their peers. With this in mind, Doral's Utilization Management Programs are designed to ensure the fair and appropriate use of Federal and State program dollars as defined by the regionally based community practice patterns of local dentists and their peers.

All utilization management analysis, evaluations and outcomes are related to these patterns. Doral's Utilization Management Programs recognize that there exists a normal individual dentist variance within these patterns among a community of dentists and accounts for such variance. Also, specialty dentists are evaluated as a separate group and not with general dentists since the types and nature of treatment may differ.

Doral will monitor the quality of services delivered under the Provider Agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of dental care which is recognized as acceptable professional practice in the respective community in which the Provider practices and/or the standards established by DMAS for the ***Smiles For Children*** program.

7.03 Evaluation

Doral's Utilization Management Programs evaluate claims submissions in such areas as:

- Diagnostic and preventive treatment;
- Patient treatment planning and sequencing;
- Types of treatment;
- Treatment outcomes; and
- Treatment cost effectiveness.

7.04 Results

With the objective of ensuring the fair and appropriate distribution of these "budgeted" Medicaid Assistance Dental Program dollars to dentists, Doral's Utilization Management Programs will help identify those dentists whose patterns show significant deviation from the normal practice patterns of the community of their peer dentists (typically less than 5% of all dentists). When

presented with such information, dentists may be asked to implement slight modification of their diagnosis and treatment processes that bring their practices back within the normal range. However, in some isolated instances, it may be necessary to recover reimbursement. Providers will be required to refund payments if they are found to have billed contrary to law, regulation, or DMAS/Doral policy or failed to maintain adequate documentation to support their claims. Providers have the right to appeal these review findings in accordance with the procedures described in Section 14.(b) of the ***Smiles For Children*** provider agreement.

7.05 Fraud and Abuse (Policies 700 Series)

Doral is committed to detecting, reporting and preventing potential fraud and abuse. Fraud and abuse for the ***Smiles For Children*** are defined as:

Fraud: Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or state law.

Member Abuse: Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault.

Provider Practice Patterns: (Aberrant Utilization) Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care may be referred to the appropriate state regulatory agency.

Member Fraud: If a Provider suspects a member of ID fraud, drug-seeking behavior, or any other fraudulent behavior should be reported to Doral.

8.00 Quality Improvement Program (Policies 200 Series)

Doral currently administers a Quality Improvement Program. The Quality Improvement Program includes but is not limited to:

- Provider credentialing and recredentialing
- Member satisfaction surveys
- Provider satisfaction surveys
- Random Chart Audits
- Member Grievance Monitoring and Trending
- Peer Review Process
- Utilization Management and practice patterns
- Quarterly Quality Indicator tracking (i.e. member complaint rate, appointment waiting time, access to care, etc.)

A copy of Doral's QI Program, is available upon request by contacting Doral's Customer Service department at 888.912.3456 or via e-mail at:

denelig.benefits@doralusa.com

9.00 Credentialing (Policies - 300 Series)

Doral in conjunction with DMAS has the sole right to determine which dentists (DDS or DMD) it shall accept and continue as Participating Providers. The purpose of the credentialing plan is to provide a general guide for the acceptance, discipline and termination of Participating Providers. Doral considers each Provider's potential contribution to the objective of providing effective and efficient dental services to ***Smiles for Children*** Members.

Upon receipt from a potential new provider of a signed Agreement and application for participation in the ***Smiles For Children*** program, Doral will verify the following credentialing criteria:

- National Provider Identifier number
- Current licensure status
- History of State licensing sanctions or reprimands
- Medicare/Medicaid sanction history
- Malpractice claims history

Following successful verification, the Provider will be enrolled as a Participating Provider in the ***Smiles For Children*** program.

Nothing in this Credentialing Plan limits Doral's sole discretion to accept and discipline Participating Providers. No portion of this Credentialing Plan limits Doral's right to permit restricted participation by a dental office or Doral's ability to terminate a Provider's participation in accordance with the Participating Provider's written agreement, instead of this Credentialing Plan.

DMAS has the final decision-making power regarding network participation. Doral will notify DMAS of all disciplinary actions enacted upon Participating Providers.

Appeal of Credentialing Committee Recommendations. (Policy 300.017)
If the Credentialing Committee recommends acceptance with restrictions or the denial of an application, the Committee will offer the applicant an opportunity to appeal the recommendation.

The applicant must request a reconsideration/appeal in writing and the request must be received by Doral within 30 days of the date the Committee gave notice of its decision to the applicant.

Discipline of Providers (Policy 300.019)

Procedures for Discipline and Termination (Policies 300.017-300.021)

Recredentialing (Policy 300.016)
Network providers are recredentialed at least every 36 months as required by DMAS.

Note: The aforementioned policies are available upon request by contacting Doral's Customer Service at 888.912.3456 or via e-mail at:

denelig.benefits@doralusa.com

10.00 The Patient Record

A. Organization

1. The record must have areas for documentation of the following information:

   a. Registration data including a complete health history.
   b. Medical alert predominantly displayed inside chart jacket.
   c. Initial examination data.
   d. Radiographs.
   e. Periodontal and Occlusion status.
   f. Treatment plan/Alternative treatment plan.
   g. Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.
   h. Miscellaneous items (correspondence, referrals, and clinical laboratory reports).

2. The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information.

   a. Health history.
   b. Medical alert.
   c. Examination/Recall data.
   d. Periodontal status.
   e. Treatment plan.

3. The design of the record must ensure that all permanent components of the record are attached or secured within the record.

4. The design of the record must ensure that all components must be readily identified to the patient, i.e., patient name, and identification number on each page.

5. The organization of the record system must require that individual records be assigned to each patient.

B. Content-The patient record must contain the following:

1. Adequate documentation of registration information which requires entry of these items:

   a. Patient's first and last name.
   b. Date of birth.
   c. Sex.
   d. Address.
   e. Telephone number.
   f. Name and telephone number of the person to contact in case of emergency.

2. An adequate health history that requires documentation of these items:

   a. Current medical treatment.
   b. Significant past illnesses.
   c. Current medications.
   d. Drug allergies.
   e. Hematologic disorders.
   f. Cardiovascular disorders.

g. Respiratory disorders.
h. Endocrine disorders.
i. Communicable diseases.
j. Neurologic disorders.
k. Signature and date by patient.
l. Signature and date by reviewing dentist.
m. History of alcohol and/or tobacco usage including smokeless tobacco.

3. An adequate update of health history at subsequent recall examinations which requires documentation of these items:

   a. Significant changes in health status.
   b. Current medical treatment.
   c. Current medications.
   d. Dental problems/concerns.
   e. Signature and date by reviewing dentist.

4. A conspicuously placed medical alert inside chart jacket that documents highly significant terms from health history. These items are:

   a. Health problems which contraindicate certain types of dental treatment.
   b. Health problems that require precautions or pre-medication prior to dental treatment.
   c. Current medications that may contraindicate the use of certain types of drugs or dental treatment.
   d. Drug sensitivities.
   e. Infectious diseases that may endanger personnel or other patients.

5. Adequate documentation of the initial clinical examination which is dated and requires descriptions of findings in these items:

   a. Blood pressure. (Recommended)
   b. Head/neck examination.
   c. Soft tissue examination.
   d. Periodontal assessment.
   e. Occlusion classification.
   f. Dentition charting.

6. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations which is dated and requires descriptions of changes/new findings in these items:

   a. Blood pressure (Recommended).
   b. Head/neck examination.
   c. Soft tissue examination.
   d. Periodontal assessment.
   e. Dentition charting.

7. Radiographs which are:

   a. Identified by patient name.
   b. Dated.
   c. Designated by patient's left and right side.
   d. Mounted (if intraoral films).

8. An indication of the patient's clinical problems/diagnosis

9. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:

    a. Procedure.
    b. Localization (area of mouth, tooth number, surface).

10. An adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:

    a. Periodontal pocket depth.
    b. Furcation involvement.
    c. Mobility.
    d. Recession.
    e. Adequacy of attached gingiva.
    f. Missing teeth.

11. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:

    a. Gingival status.
    b. Amount of plaque.
    c. Amount of calculus.
    d. Education provided to the patient.
    e. Patient receptiveness/compliance.
    f. Recall interval.
    g. Date.

12. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:

    a. Provider to whom consultation is directed.
    b. Information/services requested.
    c. Consultant's response.

13. Adequate documentation of treatment rendered which requires entry of these items:

    a. Date of service/procedure.
    b. Description of service, procedure and observation.
    c. Type and dosage of anesthetics and medications given or prescribed.
    d. Localization of procedure/observation, (tooth #, quadrant etc.).
    e. Signature of the provider who rendered the service.

14. Adequate documentation of the specialty care performed by another dentist that includes:

    a. Patient examination.
    b. Treatment plan.
    c. Treatment status.

C. Compliance

1. The patient record has one explicitly defined format that is currently in use.
2. There is consistent use of each component of the patient record by all staff.
3. The components of the record that are required for complete documentation of each patient's status and care are present.
4. Entries in the records are legible.
5. Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice.

11.00 Patient Recall System

A. Recall System Recommendation

Each participating Doral Provider office may maintain and document, a formal system for patient recall. The system can utilize either written or phone contact. Any system should encompass routine patient check-ups, cleaning appointments, follow-up treatment appointments, and missed appointments for any ***Smiles For Children*** Member that has sought dental treatment.

If a written process is utilized, the following or similar language is suggested for missed appointments:

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Dental offices indicate that patients sometimes fail to show up for appointments. Doral offers the following suggestions to decrease the "no show" rate.

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.

B. Doral Appointment Assistance

Doral's Customer Service Department uses technology to link ***Smiles For Children*** Members to the closest and most appropriate dental provider. On occasion, Members require special assistance making appointments due to geographic or special physical needs. Doral's Customer Service department includes Member Placement Specialists, responsible for locating providers for Members in emergency or difficult situations. These Member Placement Specialists will assist Members with making appointments with a Participating Provider. Doral will also place reminder phone calls prior to the appointment, to any Member for which Doral's Member Placement Specialist has assisted in scheduling the appointment.

C. Effective Communication

Doral expects that participating ***Smiles For Children*** dentists will provide contracted services without discrimination to Medicaid enrollees with special needs. This includes providing or arranging for communication assistance, such as interpreter services, for persons with communication and language barriers.

D. Non-Compliant Members

Doral will proactively educate Members on the importance of keeping appointments through various outreach and educational materials, including member newsletters, member handbook, and outreach. Doral will contact and educate ***Smiles For Children*** Members who have been identified by providers as non-compliant.

Providers and dental offices are not allowed to charge members for missed appointments.

E. Office Compliance Verification Procedures

- Participating ***Smiles For Children*** Dentists are expected to meet minimum standards with regards to appointment availability. The standards are:

    - Emergency care – As quickly as the situation warrants
    - Urgent care – Within 48 hours
    - Routine care – Not to exceed 6 weeks

12.00 Radiology Requirements

Note: Please refer to benefit tables for radiograph benefit limitations

Doral utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health Panel (the Panel). These guidelines were developed in conjunction with the Food and Drug Administration.

A. Radiographic Examination of the New Patient

1. Child – Primary Dentition

   The Panel recommends Posterior Bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts.

2. Child – Transitional Dentition

   The Panel recommends an individualized Periapical/Occlusal examination with Posterior Bitewings OR a Panoramic Radiograph and Posterior Bitewings, for a new patient with a transitional dentition.

3. Adolescent – Permanent Dentition Prior to the eruption of the third molars

   The Panel recommends an individualized radiographic examination consisting of selected Periapicals with posterior Bitewings for a new adolescent patient.

4. Adult – Dentulous

   The Panel recommends an individualized radiographic examination consisting of selected Periapicals with posterior Bitewings for a new dentulous adult patient.

5. Adult – Edentulous

   The Panel recommends a Full-Mouth Intraoral Radiographic Survey OR a Panoramic Radiograph for the new edentulous adult patient.

B. Radiographic Examination of the Recall Patient

1. Patients with clinical caries or other high – risk factors for caries

   a. Child – Primary and Transitional Dentition

      The Panel recommends that Posterior Bitewings be performed at a 6-12 month interval for those children with clinical caries or who are at increased risk for the development of caries in either the primary or transitional dentition.

   b. Adolescent

      The Panel recommends that Posterior Bitewings be performed at a 6-12 month interval for adolescents with clinical caries or who are at increased risk for the development of caries.

   c. Adult – Dentulous

The Panel recommends that Posterior Bitewings be performed at a 6-12 month interval for adults with clinical caries or who are at increased risk for the development of caries.

d. Adult – Edentulous

The Panel found that an examination for occult disease in this group cannot be justified on the basis of prevalence, morbidity, mortality, radiation dose and cost. Therefore, the Panel recommends that no radiographs be performed for edentulous recall patients without clinical signs or symptoms.

2. Patients with no clinical caries and no other high risk factors for caries

a. Child – Primary Dentition

The Panel recommends that Posterior Bitewings be performed at an interval of 12-24 months for children with a primary dentition with closed posterior contacts that show no clinical caries and are not at increased risk for the development of caries.

b. Adolescent

The Panel recommends that Posterior Bitewings be performed at intervals of 12-24 months for patients with a transitional dentition who show no clinical caries and are not at an increased risk for the development of caries.

c. Adult – Dentulous

The Panel recommends that Posterior Bitewings be performed at intervals of 24-36 months for dentulous adult patients who show no clinical caries and are not at an increased risk for the development of caries.

3. Patients with periodontal disease, or a history of periodontal treatment for Child – Primary and Transitional Dentition, Adolescent and Dentulous Adult

The Panel recommends an individualized radiographic survey consisted of selected Periapicals and/or Bitewing radiographs of areas with clinical evidence or a history of periodontal disease, (except nonspecific gingivitis).

4. Growth and Development Assessment

a. Child – Primary Dentition

The panel recommends that prior to the eruption of the first permanent tooth, no radiographs be performed to assess growth and development at recall visits in the absence of clinical signs or symptoms.

b. Child – Transitional Dentition

The Panel recommended an individualized Periapical/Occlusal series OR a Panoramic Radiograph to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

c. Adolescent

The Panel recommended that for the adolescent (age 16-19 years of age) recall patient, a single set of Periapicals of the wisdom teeth OR a Panoramic Radiograph.

d. Adult

The Panel recommends that no radiographs be performed on adults to assess growth and development in the absence of clinical signs or symptoms.

13.00 Health Guidelines – Ages 0-18 Years

NOTE: Please refer to benefit tables for benefits and limitations.

Recommendations for Preventive Pediatric Dental Care (AAPD Reference Manual 2002-2003)

Periodicity and Anticipatory Guidance Recommendations (AAPD/ADA/AAP guidelines)

PERIODICITY RECOMMENDATIONS					
Age (1)	**Infancy 6 – 12 Months**	**Late Infancy 12 – 24 Months**	**Preschool 2 – 6 Years**	**School Aged 6 – 12 Years**	**Adolescence 12 – 18 Years**
Oral Hygiene Counseling (2)	Parents/ guardians/ caregivers	Parents/ guardians/ caregivers	Patient/parents/ guardians/ caregivers	Patient/ parents/ caregivers	Patient
Injury, Prevention Counseling (3)	X	X	X	X	X
Dietary Counseling (4)	X	X	X	X	X
Counseling for non-nutritive habits (5)	X	X	X	X	X
Fluoride Supplementation (6,7)	X	X	X	X	X
Assess oral growth and development (8)	X	X	X	X	X
Clinical oral exam	X	X	X	X	X
Prophylaxis and topical fluoride treatment (9)		X	X	X	X
Radiographic assessment (10)			X	X	X
Pit and Fissure Sealants			If indicated on primary molars	First permanent molars as soon as possible after eruption	Second permanent molars and appropriate premolars as soon as possible after eruption
Treatment of dental disease	X	X	X	X	X
Assessment and treatment of developing malocclusion			X	X	X
Substance abuse counseling				X	X
Assessment and/or removal of third molars					X
Referral for regular periodic dental care					X
Anticipatory guidance (11)	X	X	X	X	X

1. First examination at the eruption of the first tooth and no later than 12 months.
2. Initially, responsibility of parent; as child develops jointly with parents, then when indicated, only by child.
3. Initially play objects, pacifiers, car seats; then when learning to walk; sports, routine playing and intraoral/perioral piercing.
4. At every appointment discuss role of refined carbohydrates; frequency of snacking.
5. At first discuss need for additional sucking; digits vs. pacifiers; then the need to wean from habit before eruption of a permanent incisor.
6. As per American Academy of Pediatrics/American Dental Association guidelines and the water source.
7. Up to at least 16 years.
8. By clinical examination.
9. Especially for children at high risk for caries and periodontal disease.
10. As per AAPD Guideline on Prescribing Dental Radiographs.
11. Appropriate discussion and counseling should be an integral part of each visit for care.

14.00 Clinical Criteria

The criteria outlined in Doral's Provider Office Reference Manual are based around procedure codes as defined in the American Dental Association's Code Manuals. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or descriptive narratives. In some instances, the State legislature will define the requirements for dental procedures.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must meet and satisfy specific DMAS requirements as well. They are designed as *guidelines* for authorization and payment decisions and *are not intended to be all-inclusive or absolute*. Additional narrative information is appreciated when there may be a special situation.

We hope that the enclosed criteria will provide a better understanding of the decision-making process for reviews. We also recognize that "local community standards of care" may vary from region to region and will continue our goal of incorporating generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards. Your feedback and input regarding the constant evolution of these criteria is both essential and welcome. Doral shares your commitment and belief to provide quality care to ***Smiles For Children*** Members and we appreciate your participation in the program.

14.01 Criteria for Dental Extractions

Some procedures require pre-payment review documentation. Please refer to the benefit tables for specific information needed by code.

Documentation needed for procedure:

- Appropriate pre-operative radiographs showing clearly the adjacent and opposing teeth should be submitted: bitewings, periapicals or panorex.
- Narrative demonstrating medical necessity.

Criteria

The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology (for orthodontics) may be covered subject to consultant review.

- The removal of primary teeth whose exfoliation is imminent does not meet criteria.
- Alveoloplasty (code D7310) in conjunction with three or more extractions in the same quadrant will be covered.

14.02 Criteria for Cast Crowns

Some procedures require pre-payment review documentation. Please refer to the benefit tables for specific information needed by code.

Documentation needed for procedure:

- Appropriate pre-operative radiographs showing clearly the adjacent and opposing teeth should be submitted: bitewings, periapicals or panorex.

Criteria

- In general, criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four or more surfaces and at least 50% of the incisal edge.

A request for a crown following root canal therapy must meet the following criteria:

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

- The patient must be free from active and advanced periodontal disease.
- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.
- Cast Crowns on permanent teeth are expected to last, at a minimum, five years.

Payment for Crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.

14.03 Criteria for Endodontics

Some procedures require pre-payment review documentation. Please refer to the benefit tables for specific information needed by code.

Documentation needed for procedure:

- Sufficient and appropriate pre-operative radiographs showing clearly the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex.

Criteria

Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.

Root canal therapy must meet the following criteria:

- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.

- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Payment for Root Canal therapy will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).

- The general oral condition does not justify root canal therapy due to loss of arch integrity.

- Root canal therapy is for third molars, unless they are an abutment for a partial denture.

- Tooth does not demonstrate 50% bone support.

- Root canal therapy is in anticipation of placement of an overdenture.

- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.

Other Considerations

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root canal fill radiograph.

- In cases where the root canal filling does not meet Doral's treatment standards, Doral can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after Doral reviews the circumstances.

14.04 Criteria for Stainless Steel Crowns

Authorization or pre-payment review is not required.

Criteria

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and at least 50% of the incisal edge.
- Primary molars must have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

A crown on a permanent tooth following root canal therapy must meet the following criteria:

- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

- The patient must be free from active and advanced periodontal disease.
- The permanent tooth must be at least 50% supported in bone.
- Stainless Steel Crowns on permanent teeth are expected to last five years.

Treatment using Stainless Steel Crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth with exfoliation imminent.
- Crowns are being planned to alter vertical dimension.

14.05 Criteria for Authorization of Operating Room (OR) Cases

Documentation needed for authorization of procedure:

- Treatment Plan (prior-authorized, if necessary).
- Narrative describing medical necessity for OR.

Please mail requests for OR authorization to:

Doral Dental USA, LLC-OR Authorizations
P.O. Box 339
Mequon, WI 53092

All Operating Room (OR) Cases Must be Authorized.

The Participating ***Smiles For Children*** Provider should submit the prior authorization. Doral will serve as the central point of contact for the dental provider, medical facility, medical anesthesiologist, MCO, DMAS and any other required provider. Doral's dental director will review the case for medical necessity, and render an approval or denial of the services. Once Doral has approved the case, Doral will coordinate authorization for non-dental services (example: facility and anesthesia) with DMAS and the MCO as appropriate, within the MCO provider network.

Criteria

In most cases, OR will be authorized (for procedures covered by ***Smiles For Children***) if the following is (are) involved:

- Young children requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures if authorization documentation indicates that in-office treatment (nitrous oxide or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon Provider or Member convenience.
- Patients requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV (Class III – patients with uncontrolled disease or significant systemic disease; for recent MI, resent stroke, new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life).
- Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during extensive dental procedures.
- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate.
- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.
- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

14.06 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Some procedures require pre-payment review documentation. Please refer to the benefit tables for specific information needed by code.

Documentation needed for procedure:

- Appropriate pre-operative radiographs showing clearly the adjacent and opposing teeth: bitewings, periapicals or panorex.

Criteria

Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.

- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least 5 years old and unserviceable to qualify for replacement.
- In general, a partial denture will be approved for benefits for if it replaces one or more anterior teeth, or replaces two or more posterior teeth unilaterally or replaces three or more posterior teeth bilaterally, excluding third molars, and it can be demonstrated that masticatory function has been severely impaired. The replacement teeth should be anatomically full sized teeth.

Removable prosthesis will not meet criteria:

- If there is a pre-existing prosthesis which is not at least 5 years old and unserviceable.
- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth are less than 50% supported in bone.
- If the recipient cannot accommodate and properly maintain the prosthesis (i.e.. Gag reflex, potential for swallowing the prosthesis, severely handicapped).

- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- If a partial denture, less than five years old, is converted to a temporary or permanent complete denture.
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

Criteria

- If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.
- Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion. After that time has elapsed:
  - Adjustments will be reimbursed at one per calendar year per denture.
  - Repairs will be reimbursed at two repairs per denture per year, with five total denture repairs per 5 years.
  - Relines will be reimbursed once per denture every 36 months.
  - A new prosthesis will not be reimbursed for within 24 months of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted.
  - Replacement of lost, stolen, or broken dentures less than 5 years of age usually will not meet criteria for pre-authorization of a new denture.
- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.
- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

14.07 Criteria for the Determination of a Non-Restorable Tooth

In the application of clinical criteria for benefit determination, dental consultants must consider the overall dental health. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan.

A tooth may be deemed non-restorable if one or more of the following criteria are present:

- The tooth presents with greater than a 75% loss of the clinical crown.

- The tooth has less than 50% bone support.
- The tooth has subosseous and/or furcation caries.
- The tooth is a primary tooth with exfoliation imminent.
- The tooth apex is surrounded by severe pathologic destruction of the bone.
- The overall dental condition (i.e. periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

14.08 Criteria for General Anesthesia and Intravenous (IV) Sedation

Authorization or pre-payment review is not required.

Criteria

General anesthesia or IV sedation may be performed in conjunction with procedures covered by the ***Smiles For Children*** program if any of the following criteria are met:

Extensive or complex oral surgical procedures such as:

- Impacted wisdom teeth.
- Surgical root recovery from maxillary antrum.
- Surgical exposure of impacted or unerupted cuspids.
- Radical excision of lesions in excess of 1.25 cm.

And/or one of the following medical conditions:

- Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension).
- Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down's syndrome) which would render patient non-compliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
- Patients 3 years old and younger with extensive procedures to be accomplished.

14.09 Criteria for Periodontal Treatment

Some procedures require pre-payment review documentation. Please refer to the benefit tables for specific information needed by code.

Documentation needed for procedure:

- Radiographs – periapicals or bitewings preferred.
- Complete periodontal charting with AAP Case Type.

Periodontal scaling and root planing, per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others.

It is anticipated that this procedure would be requested in cases of severe periodontal conditions (i.e. late Type II, III, IV periodontitis) where definitive comprehensive root planing requiring local/regional block anesthesia and several appointments would be indicated.

From the American Academy of Periodontology (AAP) Policy on Scaling and Root Planing:

"Periodontal scaling is a treatment procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces. It is performed on patients with periodontal disease and is therapeutic, not prophylactic, in nature. Periodontal scaling may precede root planing, which is the definitive, meticulous treatment procedure to remove cementum and/or dentin that is rough and may be permeated by calculus, or contaminated with toxins or microorganisms. Periodontal scaling and root planing are arduous and time consuming. They may need to be repeated and may require local anesthetic."

Criteria

- A minimum of four (4) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally at least one of the following must be present:

    1) Radiographic evidence of root surface calculus.
    2) Radiographic evidence of noticeable loss of bone support.

APPENDIX A

Attachments

General Definitions

The following definitions apply to this Office Reference Manual:

A. "Agreement" means the contract between Doral acting on behalf of the ***Smiles For Children*** program and Provider.

B. "Covered Services" means a dental health care service or supply, including those services covered through the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program that satisfies all of the following criteria:

- Is medically necessary;
- Is covered under the ***Smiles For Children*** program;
- Is provided to an enrolled member by a Participating Provider
- Is the most appropriate supply or level of care that is consistent with professionally recognized standards of dental practice within the service area and applicable policies and procedures.

C. "DMAS" means the Virginia Department of Medical Assistance Services.

D. "Doral" shall refer to Doral Dental USA, LLC

E. "Doral Service Area" shall be defined as the Commonwealth of Virginia.

F. "Emergency Services" means covered dental services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard.

G. "EPSDT" means the Early and Periodic Screening, Diagnosis and Treatment program for persons (under age 21) made pursuant to 42 U.S.C. Sections 1396a(a)43, 1396d(a) and (r) and 42 C.F.R. Part 441, Subpart B to ascertain children's individual physical and mental illness and conditions discovered by the screening services, whether or not such services are covered.

H. "Medically Necessary" means covered medical, dental, behavioral, rehabilitative or other health care services which:

- are reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity or limitation in function, cause illness or infirmity, endanger life, or worsen a disability:
- are provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical conditions;
- are consistent with the diagnoses of the conditions;
- are no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency and independence; and
- will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual, and those functional capacities that are appropriate for individuals of the same age.

I. “Member or Enrollee” means any individual who is eligible to receive Covered Services provided for under the ***Smiles For Children*** program.

J. “Participating Provider or Provider” is a dental professional or facility, including a Provider Dentist, that has a written participation agreement in effect with DMAS and Doral, to provide dental services to Members of the ***Smiles For Children*** program.

K. “Claim” means any bill or claim made by or on behalf of an enrollee or the Dentist to Doral under the agreement for payment for Dental Services under the ***Smiles For Children*** program.

L. “Clean Claim” means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim form a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

M. "Provider" means the undersigned health professional or any other entity that has entered into a written agreement with Doral to provide certain health services to Members. Each Provider shall have its own distinct tax identification number.

N. “Provider Dentist” is a Doctor of dentistry, duly licensed and qualified under the laws of the Commonwealth of Virginia, who practices as a shareholder, partner, or employee of Provider.

O. “***Smiles For Children***” is the name of the dental program provided to Virginia Medicaid, FAMIS and FAMIS Plus enrollees, administered by Doral, under the direction of DMAS.

P. “FAMIS” is the DMAS program for members under the age of 19 who are eligible to receive services under the State Child Health Insurance Plan under Title XXI, as amended.

Q. “FAMIS Plus” is the DMAS program for members under the age of 19 who meet “medically indigent” criteria under Medicaid program rules, and who are assigned an aid category code of 90;90 (under 6 years of age);92 and 94. FAMIS Plus children receive the full Medicaid benefit package and have no cost-sharing responsibilities.

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First Review ✓ **Smiles For Children/VA Medicaid**
Second Review ___

Models ___
Orthocad ___
Ceph Films ___
X-Rays ___
Photos ___
Narrative ___

DORAL DENTAL SERVICES
ORTHODONTIC CRITERIA INDEX FORM – COMPREHENSIVE D8080

Patient Name: _____ DOB:_____

ABBREVIATIONS	CRITERIA for Permanent Dentition	YES	NO
DO	Deep impinging overbite that shows palatal impingement causing tissue trauma with the majority of lower incisors.		
AO	True anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted and not correctable by habit therapy).		
AP	Demonstrates a large anterior –posterior discrepancy. (Class II and Class III malocclusions that are virtually a full tooth Class II or Class III).		
AX	Anterior crossbite. (Involves more than two teeth and in cases where gingival stripping from the crossbite is demonstrated and not correctable by limited ortho treatment)		
PX	Posterior transverse discrepancies. (Involves several posterior teeth in crossbite, one of which must be a molar and not correctable by limited ortho treatment).		
PO	Significant posterior openbites. (Not involving partially erupted teeth or one or two teeth slightly out of occlusion and not correctable by habit therapy.).		
IMP	Impacted incisors or canines that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where incisors or canines are going to erupt ectopically).		
CR	Crowding of 7 – 8 mm in either the maxillary or mandibular arch.		
OJ	Overjet in excess of 9 mm.		
CDD	Dentition exhibits a profound impact from a congenital or developmental disorder.		
FAS	Significant facial asymmetry requiring a combination orthodontic and orthognathic surgery for correction.		

Approved ☐

When all are answered "NO", please refer to the Salzmann ☐

Kathie Arena, DDS David Bogenschutz, DDS William Crinzi, DDS Thomas Gengler, DDS James Thommes, DDS

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Models ___
Orthocad ___
Ceph Films ___
X-Rays ___
Photos ___
Narrative ___

First Appeal ___
Second Appeal ___

Malocclusion Severity Assessment
By J. A. Salzmann, DDS, FAPHA

Handicapping Malocclusion Assessment Record

Patient Name _____

ID# _____ Health Plan _____

INTRA-ARCH DEVIATION

Score Teeth Affected Only		Missing	Crowded	Rotated	Spacing Open	Spacing Closed	No.	Point Value	Score
Maxilla	Ant							X2	
	Post							X1	
Mandible	Ant							X1	
	Post							X1	
							Total Score		

Ant = anterior teeth (4 incisors); Post. = Posterior teeth = (Include canine, premolars and first molar).
No. = number of teeth affected

A. INTER-ARCH DEVIATION

1. Anterior Segment

Score Maxillary Teeth Affected Only Except Overbite*	Overjet	Overbite	Crossbite	Openbite	No.	P.V.	Score
						X2	
					Total Score		

*Score maxillary or mandibular incisors.
No. = number of teeth affected; P.V. = point value.

2. Posterior Segment

Score Teeth Affected Only	Related Mandibular to Maxillary Teeth				Score Affected Maxillary Teeth Only				No.	P.V.	Score
	Distal		Mesial		Crossbite		Openbite				
	Right	Left	Right	Left	Right	Left	Right	Left			
Canine											
1st Premolar											
2nd Premolar											
1st Molar											
No. = number; P.V. – point value;									Total Score		
									Grand Total		

Malocclusion Severity Assessment

By J.A. Salzmann, DDS, F.A.P.H.A.

SUMMARY OF INSTRUCTIONS

Score: 2 points for each maxillary anterior tooth affected.
1 point for each mandibular incisor and all posterior teeth affected.

1. Missing teeth. Count the teeth; remaining roots of teeth are scored as a missing tooth.
2. Crowding. Score the points when there is not sufficient space to align a tooth without moving other teeth in the same arch.
3. Rotation. Score the points when one or both proximal surfaces are seen in anterior teeth, or all or part of the buccal or lingual surface in posterior teeth are turned to a proximal surface of an adjacent tooth. The space needed for tooth alignment is sufficient in rotated teeth for their proper alignment.
4. Spacing. Score teeth, not spacing. Score the points when:
   a. Open spacing. One or both interproximal tooth surfaces and adjacent papillae are visible in an anterior tooth; both interproximal surfaces and papillae are visible in a posterior tooth.
   b. Closed spacing. Space is not sufficient to permit eruption of a tooth that is partially erupted.
5. Overjet. Score the points when the mandibular incisors occlude on or over the maxillary mucosa in back of the maxillary incisors, and the mandibular incisor crowns show labial axial inclination.
6. Overbite. Score the points when the maxillary incisors occlude on or opposite labial gingival mucosa of the mandibular incisor teeth.
7. Cross-bite. Score the points when the maxillary incisors occlude lingual to mandibular incisors, and the posterior teeth occlude entirely out of occlusal contact.
8. Open-bite. Score the points when the teeth occlude above the opposing incisal edges and above the opposing occlusal surfaces of posterior teeth.
9. Mesiodistal deviations. Relate mandibular to opposing maxillary teeth by full cusp for molars; buccal cusps of premolars and canines occlude mesial or distal to accepted normal interdental area of maxillary premolars.

Instruction for using the "Handicapping Malocclusion Assessment Record"

Introduction

This assessment record (not an examination) is intended to disclose whether a handicapping malocclusion is present and to assess its severity according to the criteria and weights (point values) assigned to them. The weights are based on tested clinical orthodontic values from the standpoint of the effect of the malocclusion on dental health, function, and esthetics. The assessment is not directed to ascertain the presence of occlusal deviations ordinarily included in epidemiological surveys of malocclusion. Etiology, diagnosis, planning, complexity of treatment, and prognosis are not factors in this assessment. Assessments can be made from casts or directly in the mouth. An additional assessment record form is provided for direct mouth assessment of mandibular function, facial asymmetry, and lower lip position.

A. INTRA-ARCH DEVIATIONS

The casts are placed, teeth upward, in direct view. When the assessment is made directly in the mouth, a mouth mirror is used. The number of teeth affected is entered as indicated in the "Handicapping Malocclusion Assessment Record." The scoring can be entered later.

1. Anterior segment A value of 2 points is scored for each tooth affected in the maxilla and 1 point in the mandible.

    a. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.

    b. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment without moving other teeth in the arch. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.

    c. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch but there is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded or spaced.

    d. Spacing

        1) Open spacing refers to tooth separation that exposes to view the interdental papilla on the alveolar crest. Score the number of papillae visible (not teeth).

        2) Closed spacing refers to partial space closure that will not permit a tooth to complete its eruption without moving other teeth in the same arch. Score the number of teeth affected.

2. Posterior segment: A value of 1 point is scored of each tooth affected.

    a. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.

    b. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.

    c. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch and all or part of the lingual or buccal surface faces some part or all of the adjacent proximal tooth surfaces. There is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded.

    d. Spacing

        1) Open spacing refers to interproximal tooth separation that exposes to view the mesial and distal papillae of a tooth. Score the number of teeth affected (Not the spaces).

        2) Closed spacing refers to partial space closure that will not permit a tooth to erupt without moving other teeth in the same arch. Score the number of teeth affected.

INTER-ARCH DEVIATIONS

When casts are assessed for interarch deviations, they first are approximated in terminal occlusion. Each side assessed is held in direct view. When the assessment is made in the mouth, terminal occlusion is obtained by bending the head backward as far as possible while the mouth is held wide open. The tongue is bent upward and backward on the palate and the teeth are quickly brought to terminal occlusion before the head is again brought downward. A mouth mirror is used to obtain a more direct view in the mouth.

1. Anterior segment: A value of 2 points is scored for each affected maxillary tooth only.

    a. Overjet refers to labial axial inclination of the maxillary incisors in relation to the mandibular incisor, permitting the latter to occlude on or over the palatal mucosa. If the maxillary incisors are not in labial axial inclination, the condition is scored as overbite only.

    b. Overbite refers to the occlusion of the maxillary incisors on or over the labial gingival mucosa of the mandibular incisors, while the mandibular incisors themselves occlude on or over the palatal mucosa in back of the maxillary incisors. When the maxillary incisors are in labial axial inclination, the deviation is scored also as overjet.

    c. Cross-bite refers to maxillary incisors that occlude lingual to their opponents in the opposing jaw, when the teeth are in terminal occlusion.

    d. Open-bite refers to vertical interarch dental separation between the upper and lower incisors when the posterior teeth are in terminal occlusion. Open-bite is scored in addition to overjet if the maxillary incisor teeth are above the incisal edges of the mandibular incisors when the posterior teeth are in terminal occlusion Edge-to-edge occlusion is not assessed as open-bite.

2. Posterior segment: A value of 1 point is scored for each affected tooth.

    a. Cross-bite refers to teeth in the buccal segment that are positioned lingually or buccally out of entire occlusal contact with the teeth in the opposing jaw when the dental arches are in terminal occlusion.

    b. Open-bite refers to the vertical interdental separation between the upper and lower segments when the anterior teeth are in terminal occlusion. Cusp-to-cusp occlusion is not assessed as open-bite.

Anteroposterior deviation refers to the occlusion forward or rearward of the accepted normal of the mandibular canine, first and second premolars, and first molar in relation to the opposing maxillary teeth. The deviation is scored when it extends a full cusp or more in the molar and the premolars and canine occlude in the interproximal area mesial or distal to the accepted normal position.

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ORTHODONTIC CONTINUATION OF CARE FORM

Member ID Number: _____

Member Name (Last/First): _____

Date of Birth: _____

Name of Previous Vendor that issued original approval:

_____

Banding Date: _____

Case Rate Approved By Previous Vendor: _____

Amount Paid for Dates of Service That Occurred Prior to Doral: _____

Amount Owed for Dates of Service That Occurred Prior to Doral: _____

Balance Expected for Future Dates of Service: _____

Number of Adjustments Remaining: _____

Additional information required:

- **Completed ADA claim form listing services to be rendered.**
- **If the member is transferring from an existing Medicaid program: A copy of the original orthodontic approval.**
- **If the member is private pay or transferring from a commercial insurance program, please enclose the original diagnostic models (or OrthoCad equivalent). Radiographs are optional.**

Mail to:

Doral
Att: Continuation of Care
12121 N. Corporate Parkway
Mequon, WI 53092

Doral's Orthodontic Pre-Authorization Checklist

(PLEASE POST IN YOUR OFFICE AS A REMINDER)

Claims

- ❑ Submit for full ortho treatment by listing CDT code **8080 on the claim** without a date of service.
- ❑ Make sure the member **ID number** is identified on the claim.
- ❑ Verify that the member ID number matches the member's name
- ❑ Verify that the member's date of birth is correct.
- ❑ Confirm the members name is spelled correctly-same name as what's listed on the member's card.
- ❑ Include a copy of the member's card if necessary
- ❑ Place the claim/paperwork **on top of the study models** in the Doral Box – please do not fold.
- ❑ Submit the claim **along with** the study models in a Doral Box.
- ❑ The claim should be **stapled on top** of any other information – x-rays being last.

Models

- ❑ Identification on study models must be clearly **marked** on both the upper and lower arch.
- ❑ Include wax bites when sending study models
- ❑ Do **not** exceed six sets of study models per Doral box.
- ❑ Verify that the name on the study models **match** the name on the claim.
- ❑ Wrap study models **securely** with bubble wrap or foam the bubble wrap is recycled.
- ❑ **Don't** submit study models using paper towels to avoid unnecessary damage during transit
- ❑ **Secure** wrapped study models **with rubber bands** (not tape)

For Your Information

- ❖ Denied orthodontic cases/study models are held at Doral for 45 days. (Exception IL)
- ❖ Any missing/incomplete pre-auth information will likely result in delayed processing.
- ❖ If needed information isn't provided within the specific time frame indicated, it is returned.
- ❖ **When faxing information**, always indicate the name of the person to **whom** you are sending it to and include "**Attention Ortho Dept.**" on the cover sheet.
- ❖ The Ortho Department fax number is 1-262-241-7150.
- ❖ **Wrap the upper and lower arches separately** with bubble wrap when submitting study models.
- ❖ A Doral box is always utilized when returning study models. Empty boxes are not provided.
- ❖ Do not remove the divider from the Doral box to avoid damage to study models during transit.
- ❖ Claims sent separately from study models have a **high potential for getting lost.**

This information serves as a guide that will allow your pre-authorization requests to be processed efficiently and rapidly. Your cooperation is appreciated!

The Doral Orthodontic Department

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Other Insured's Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐M ☐F	8. Subscriber Identifier (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Other Insured (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY INSURED INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐M ☐F	15. Subscriber Identifier (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Primary Insured (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐M ☐F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID	50. License Number	51. SSN or TIN

52. Phone Number ( ) –

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) Date

54. Provider ID	55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) –	58. Treating Provider Specialty

J515 (Same as ADA Dental Claim Form – J516, J517, J518, J519)

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 6 of the ADA Publication titled CDT-2005. Key extracts from that section of CDT-2005 follow:

General Instructions

A. The form is designed so that the Primary Payer's (primary insurance company) name and address (Item 3) are visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
C. All Items in the form must be completed unless it is noted on the form or in the comprehensive instructions that completion is not required.
D. When a name and address field is required the full name of an individual or a business, address and zip code must be entered.
E. All dates must include the four-digit year.
F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

Coordination of Benefits (COB)

When a claim is being submitted to a secondary payer, complete the form in its entirety and attach the primary payers Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "Remarks" field (Item # 35).

Items of Note

39. Number of Enclosures (00 to 99): This item is completed whether or not radiographs, oral images, or study models are submitted with the claim. If no enclosures are submitted, enter 00 in each of the boxes to verify that nothing has been sent and therefore no possible attachments are missing.

    When supplementary material is sent with the claim, the number of each type is entered in the appropriate box, using two digits. If less than 10, use 0 in the first position. 'Oral Images' include digital radiographic images and photographs and are reported by the number of images.

43. Replacement of Prosthesis?: This Item applies to Crowns and all Fixed or Removable Prostheses (e.g. bridges and dentures). Please review the following three situations in order to determine how to complete this Item.
    a) If the claim does not involve a prosthetic restoration check "NO" and proceed to Item 45.
    b) If the claim is for the initial placement of a crown, or a fixed or removable prosthesis, check "NO" and proceed to Item 45.
    c) If the patient has previously had these teeth replaced by a crown, or a fixed or removable prosthesis, or the claim is to replace an existing crown, check the "YES" field and complete section 44.

53. Certification: Signature of the treating or rendering dentist and the date the form is signed. This is the dentist who performed, or is in the process of performing, procedures indicated by date for the patient. If the claim form is being used to obtain a pre-estimate or pre-authorization, it is not necessary for the dentist to sign the form. Dentists should be aware that they have an ethical and legal obligation to refund fees for services that are paid in advance but are not completed.

Provider Taxonomy Codes

58. Treating Provider Specialty: Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

Category / Description Code	Code
Dentist / A dentist is a person qualified by a doctorate in dental surgery (D.D.S) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice / Many dentists are general practitioners who handle a wide variety of dental needs.	1223G0001X
Dental Specialty / Other dentists practice in one of the nine specialty areas recognized by the American Dental Association.	Various (see following list)
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at:
http://www.wpc-edi.com/codes/codes.asp

Any updates to ADA Dental Claim Form completion instructions will be posted on the ADA's web site at:
www.ada.org/goto/dentalcode

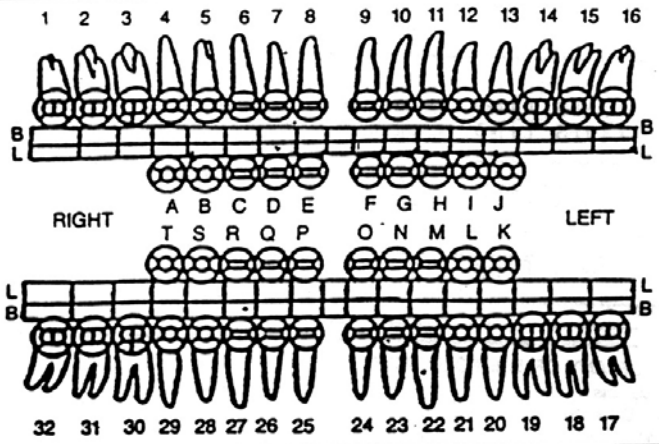
ADA
American Dental Association
www.ada.org

(Sample)

ALLERGY	PRE MED	MEDICAL ALERT

INITIAL CLINICAL EXAM

PATIENT'S NAME _____
Last First Middle



GINGIVA

MOBILITY

PROTHESIS EVALUATION

OCCLUSION 1 11 111

PATIENT'S CHIEF COMPLAINT

	OK
LYMPH NODES	
PHARYNX	
TONSILS	
SOFT PALATE	
HARD PALATE	
FLOOR OF MOUTH	
TONGUE	
VESTIBULES	
BUCCAL MUCOSA	
LIPS	
SKIN	
TMJ	
ORAL HYGIENE	
PERIO EXAM	

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

RECOMMENDED TREATMENT PLAN

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST DATE

Note: The above form is only intended to be a sample. Doral is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

RECALL EXAMINATION

(Sample)

PATIENT'S NAME _____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

	OK		OK	CLINICAL FINDINGS/COMMENTS
LYMPH NODES		TMJ		
PHARYNX		TONGUE		
TONSILS		VESTIBULES		
SOFT PALATE		BUCCAL MUCOSA		
HARD PALATE		GINGIVA		
FLOOR OF MOUTH		PROSTHESIS		
LIPS		PERIO EXAM		
SKIN		ORAL HYGIENE		

RADIOGRAPHS	B/P	RDH/DDS

R **WORK NECESSARY** **L**

TOOTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
SERVICE																
TOOTH	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
SERVICE																

COMMENTS: _____

RECALL EXAMINATION

PATIENT'S NAME _____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

	OK		OK	CLINICAL FINDINGS/COMMENTS
LYMPH NODES		TMJ		
PHARYNX		TONGUE		
TONSILS		VESTIBULES		
SOFT PALATE		BUCCAL MUCOSA		
HARD PALATE		GINGIVA		
FLOOR OF MOUTH		PROSTHESIS		
LIPS		PERIO EXAM		
SKIN		ORAL HYGIENE		

RADIOGRAPHS	B/P	RDH/DDS

R **WORK NECESSARY** **L**

TOOTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
SERVICE																
TOOTH	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
SERVICE																

COMMENTS: _____

<u>NOTE</u>: The above form is only intended to be a sample. Doral is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

Authorization for Dental Treatment

(Sample Form)

I hereby authorize Dr. _____ and his/her associates to provide dental services, prescribe, dispense and/or administer any drugs, medicaments, antibiotics, and local anesthetics that he/she or his/her associates deem, in their professional judgement, necessary or appropriate in my care.

I am informed and fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic, or local anesthetic. I am informed and fully understand that there are inherent risks involved in any dental treatment and extractions (tooth removal). The most common risks can include, but are not limited to:

> Bleeding, swelling, bruising, discomfort, stiff jaws, infection, aspiration, paresthesia, nerve disturbance or damage either temporary or permanent, adverse drug response, allergic reaction, cardiac arrest.

I realize that it is mandatory that I follow any instructions given by the dentist and/or his/her associates and take any medication as directed.

Alternative treatment options, including no treatment, have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

Procedure(s): _____

Tooth Number(s): _____

Date: _____

Dentist: _____

Patient Name: _____

Legal Guardian/
Patient Signature: _____

Witness: _____

Note: The above form is only intended to be a **sample**. Doral is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

MEDICAL AND DENTAL HISTORY
(Sample)

Patient Name: _____ Date of Birth: _____

Address: _____

Why are you here today? _____

Are you having pain or discomfort at this time? □ Yes □ No

If yes, what type and where? _____

Have you been under the care of a medical doctor during the past two years? □ Yes □ No

Medical Doctor's Name: _____

Address: _____

Telephone: _____

Have you taken any medication or drugs during the past two years? □ Yes □ No

Are you now taking any medication, drugs, or pills? □ Yes □ No

If yes, please list medications: _____

Are you aware of being allergic to or have you ever reacted badly to any medication or substance? □ Yes □ No

If yes, please list: _____

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness or breath, or because you are very tired? □ Yes □ No

Do your ankles swell during the day? □ Yes □ No

Do you use more than two pillows to sleep? □ Yes □ No

Have you lost or gained more than 10 pounds in the past year? □ Yes □ No

Do you ever wake up from sleep and feel short of breath? □ Yes □ No

Are you on a special diet? □ Yes □ No

Has your medical doctor ever said you have cancer or a tumor? □ Yes □ No

If yes, where? _____

Do you use tobacco products (smoke or chew tobacco)? □ Yes □ No

If yes, how often and how much? _____

Do you drink alcoholic beverages (beer, wine, whiskey, etc.)? □ Yes □ No

Do you have or have you had any disease, or condition not listed? □ Yes □ No

If yes, please list: _____

Indicate which of the following your have had, or have at present. Circle "Yes" or "No" for each item.

Heart Disease or Attack	□ Yes	□ No	Artificial Joints (Hip, Knee, etc.)	□ Yes	□ No	Hepatitis A (infectious)	□ Yes	□ No
Heart Failure	□ Yes	□ No	Stroke	□ Yes	□ No	Hepatitis B (serum)	□ Yes	□ No
Angina Pectoris	□ Yes	□ No	Kidney Trouble	□ Yes	□ No	Hepatitis C	□ Yes	□ No
Congenital Heart Disease	□ Yes	□ No	High Blood Pressure	□ Yes	□ No	Arteriosclerosis (hardening of arteries)	□ Yes	□ No
Kidney Trouble	□ Yes	□ No	Venereal Disease	□ Yes	□ No	Ulcers	□ Yes	□ No
Diabetes	□ Yes	□ No	Heart Murmur	□ Yes	□ No	AIDS	□ Yes	□ No
HIV Positive	□ Yes	□ No	Glaucoma	□ Yes	□ No	Blood Transfusion	□ Yes	□ No
High Blood Pressure	□ Yes	□ No	Cortisone Medication	□ Yes	□ No	Cold sores/Fever blisters/ Herpes	□ Yes	□ No
Mitral Valve Prolapse	□ Yes	□ No	Cosmetic Surgery	□ Yes	□ No	Artificial Heart Valve	□ Yes	□ No
Emphysema	□ Yes	□ No	Anemia	□ Yes	□ No	Heart Pacemaker	□ Yes	□ No
Chronic Cough	□ Yes	□ No	Heart Surgery	□ Yes	□ No	Sickle Cell Disease	□ Yes	□ No
Tuberculosis	□ Yes	□ No	Bruise Easily	□ Yes	□ No	Asthma	□ Yes	□ No
Liver Disease	□ Yes	□ No	Rheumatic fever	□ Yes	□ No	Yellow Jaundice	□ Yes	□ No
Arthritis	□ Yes	□ No	Hay Fever	□ Yes	□ No	Rheumatism	□ Yes	□ No
Allergies or Hives	□ Yes	□ No	Epilepsy or Seizures	□ Yes	□ No	Fainting or Dizzy Spells	□ Yes	□ No
Sinus Trouble	□ Yes	□ No	Nervousness	□ Yes	□ No	Chemotherapy	□ Yes	□ No
Pain in Jaw Joints	□ Yes	□ No	Radiation Therapy	□ Yes	□ No	Drug Addiction	□ Yes	□ No
Hay Fever	□ Yes	□ No	Thyroid Problems	□ Yes	□ No	Psychiatric Treatment	□ Yes	□ No

For Women Only:

Are you pregnant? □ Yes □ No

If yes, what month? _____

Are you nursing? □ Yes □ No

Are you taking birth control pills? □ Yes □ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient Signature: _____ Date: _____

Dentist's Signature: _____ Date: _____

Review Date	Changes in Health Status	Patient's Signature	Dentist's signature

Note: The above form is only intended to be a sample. Doral is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines

Provider Change Form

Our goal is to provide you effective and efficient dental administration services. To accomplish this, it is important that we have current information on you and your offices. Please use this form to notify us of any changes that affect our ability to process your claims quickly and completely.

Section 1: Current Information

Name:

Address:

City: State: Zipcode:

Telephone: E-mail:

Fax:

Section 2: Location Change / Add Location / Payee Name Change

☐ Additional Location ☐ Payee Name Change Only

☐ Relocation of Existing Office

Location Name:
(if applicable)

Address:

City: State: Zipcode:

Telephone: E-mail:

Fax:

Section 3: Tax ID Change

Old Tax ID Number: New Tax ID Number:

Section 4: Provider Status Change

☐ Add new Provider at location listed above

New Provider Name:

☐ Delete Provider at location listed above

Reason for removal:

Please return this form to: Signature: _____ Date: _____

Doral
12121 North Corporate Parkway
Mequon, WI 53092
FAX: 262.241.4077

Please be advised that changes in these areas will likely require additional paperwork, a possible site visit, and credentialing processes. We will contact you and work with you to complete any additional steps. Thank you for your cooperation.

Doral™
A DentaQuest Ventures Company

Smiles For Children
Improving Dental Care Across Virginia

Smiles For Children Broken Appointments

Last Name	First Name	Medicaid ID Number (12 digits)	Date of Broken Appointment	Provider Name	Doral Provider ID Number

Please fax this form to 804-217-8350.

Doral Dental
COMPANION GUIDE FOR ANSI HEALTH CARE TRANSACTIONS FOR

DENTAL

TABLE OF CONTENTS

Article I Introduction

Section 1.01 Intended Users

The Companion Guide transaction document is intended for the technical staff of the external entities that will be responsible for the electronic transaction/file exchanges with Doral Dental. The Companion Guide is available to external entities (providers, third party processors, clearinghouses, and billing services) to clarify the information on HIPAA-compliant electronic interfaces with Doral. Detailed implementation guide information is contained for the 837D Healthcare claim transaction in the second section of this guide.

Section 1.02 HIPAA Overview

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services to establish national standards for electronic healthcare transactions and national identifiers for providers, health plans, and employers. HIPAA also addresses the security and privacy of health data. Adopting standards will eventually improve the efficiency and effectiveness of the nation's healthcare system by encouraging the widespread use of electronic data interchange in healthcare. The intent of the law is that all electronic transactions, for which standards are specified, must be conducted according to the standards. The standards were not imposed by the law, but instead were developed by a process that included significant public and private sector input. Covered entities are required to accept these transmissions in the standard format in which they are sent and must not delay a transaction or adversely affect an entity that wants to conduct the transactions electronically.

Section 1.03 HIPAA Background

In the early 1990s, the first Bush Administration assembled an advisory group of healthcare industry leaders to discuss ways to reduce health care administrative costs across the nation. This group, which is now recognized as the Workgroup for Electronic Data Interchange (WEDI), recommended that Federal legislation be passed to implement a nationwide standard of transaction and code sets to be used by the healthcare industry. This law was entitled “The Health Insurance Portability and Accountability Act” and was enacted on August 21, 1996 under the Clinton Administration.

HIPAA requires several provisions. One provision, already in effect, deals with the portability of health insurance coverage during a change in employment, and primarily affects employers and health insurers. Another provision, often referred to “Administrative Simplification”, deals with the implementation of healthcare standards, of which transaction and code sets are but one part. Following is a list of the standard healthcare transactions and their accompanying transaction sets that Doral Dental will support:

(a) Eligibility Inquiry and Response: HIPAA mandates X12 Version 4010A1 of the 270/271 Eligibility and Benefit Inquiry and Response EDI Transactions for this purpose.

(b) Claim Status Inquiry and Response: HIPAA mandates X12 Version 4010A1 of the 276/277 Claim Status Inquiry and Response EDI Transaction for this purpose.

(c) Referral Certification and Authorization: HIPAA mandates X12 Version 4010A1 of the 278 Health Care Service Review EDI Transaction for this purpose.

(d) Premium Payment and Remittance Advice: HIPAA mandates X12 Version 4010A1 of the 820 Group Premium Payment EDI Transaction for this purpose.

(e) Enrollment and Disenrollment: HIPAA mandates X12 Version 4010A1 of the 834 Benefit Enrollment and Maintenance EDI Transaction for this purpose.

(f) Claim Payment and Remittance Advice: HIPAA mandates X12 Version 4010A1 of the 835 Healthcare Claim Payment/Advice EDI Transaction for this purpose.

(g) Claims and Encounters: HIPAA mandates the X12 Version 4010A1 of the 837I for Institutional transactions, 837D for Dental transactions, and 837P for Professional transactions. HIPAA mandates NCPDP 5.1 for interactive pharmacy transactions and NCPDP 1.1 for pharmacy batch transactions.

HIPAA also requires the standardization of code sets. Any coded field or data element contained in a HIPAA transaction must adhere to a national set of code set values, including dental procedures. As such, with implementation of the HIPAA standard transactions, only published code sets will be allowed.

Section 1.04 Additional HIPAA Requirements

In addition to the transaction and code set aspects, there are other requirements of the "Administrative Simplification" provision of HIPAA:

(a) Privacy: Standards must be adopted by all health plans, clearinghouses, and providers that ensure the protection and appropriate disclosure of individually identifiable health information. The final rule had a mandatory implementation of April 14, 2003.

(b) Security: Standards must be adopted by all health plans, clearinghouses, and providers that ensure the integrity and confidentiality of healthcare information. The security rule addresses healthcare information in all types of media instead of just electronic format. The final rule has an implementation date of April 2005.

(c) National Identifier Codes: Standards must be adopted by all health plans, clearinghouses, and providers regarding unique identifiers for providers, plans, employers, and individuals (beneficiaries). Presently, a final rule has been issued for the Employer ID. The Department of Health and Human Services has not published final rules for the remaining identifiers.

(d) Enforcement: The Office of Civil Rights has been appointed to enforce the privacy rule and has been given the authority to levy penalties for compliance failures. CMS has been designated to monitor the transaction and code sets compliance.

Although this Companion Guide deals with only one aspect of the entire "Administrative Simplification" provision, it is worth noting that all covered entities (health plans, clearinghouses, and providers) and their business partners are required to adhere to all aspects of the provision.

Section 1.05 HIPAA Internet Links

The following is a list of government agencies, industry leaders, and transaction and code set standards organizations associated with HIPAA. Although not an exhaustive list, the information located in these resources represents a wealth of information that could not otherwise be included in this Companion Guide.

Accredited Standards Committee (ASC X12) - ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. http://www.x12.org/

American Dental Association (ADA) - The Dental Terminology 3rd and 4th Edition codes (CDT-4, HCPCS Level II "D" codes) and the Dental Content Committee that sets standards for the dental claim form and maintains dental codes can be linked from this site. http://www.ada.org

Association for Electronic Health Care Transactions (AFEHCT) - A healthcare association dedicated to promoting the interchange of

electronic healthcare information. http://www.afehct.org

Centers for Medicare and Medicaid Services (CMS) - Formerly known as HCFA, this site provides links to multiple web sites. The Electronic Health Care Transactions and Code Sets Model Compliance Plan. http://www.cms.gov/hipaa/hipaa3 The Healthcare Common Procedure Coding System (HCPCS). http://cms.hhs.gov/medicare/hcpcs For Medicaid HIPAA information related to the Administrative Simplification provision. http://www.cms.gov/medicaid/hipaa/adminsim For HIPAA administrative simplification questions, CMS maintains an e-mail address at askhipaa@cms.hhs.gov and a toll free number at (866) 282-0659.

Designated Standard Maintenance Organizations (DSMO) - This site is a resource for information about the standard setting organizations, and transaction change request system. http://www.hipaa-dsmo.org

Health Level Seven (HL7) - HL7 is one of several ANSI accredited Standards Development Organizations (SDO), and is responsible for clinical and administrative data standards. http://www.hl7.org

Medicaid HIPAA Compliant Concept Model (MHCCM) -
This site presents the Medicaid HIPAA Compliance Concept Model, information and a toolkit. http://www.mhccm.org

Office for Civil Rights (OCR) - OCR is the Health and Human Services Office responsible for enforcing the Privacy Rule under HIPAA. http://www.hhs.gov/ocr/hipaa For HIPAA privacy questions, OCR can be contacted at OCRPrivacy@hhs.gov or by calling (866) 627-7748.

United States Department of Health and Human Services (DHHS) - This site is a resource for the Notice of Proposed Rule Making, and lists rules and other information regarding HIPAA. http://aspe.hhs.gov/admnsimp

Washington Publishing Company (WPC) - WPC is the official publisher for HIPAA transaction implementation guides and code sets. http://www.wpc-edi.com/hipaa

Workgroup for Electronic Data Interchange (WEDI) - A workgroup dedicated to improving healthcare through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative simplification provisions of HIPAA. http://www.wedi.org

Article II TRADING PARTNER AGREEMENTS

Section 2.01 General Overview

Separate Trading Partner Agreements for the purpose of processing and exchanging specified healthcare transactions with Doral providers will not be required.

Section 2.02 Doral Electronic Data Interchange Exchange Form

Doral will require an EDI Exchange form to be completed for each business entity desiring to exchange transaction information. The EDI Exchange Form is completed by the entity and provides a summary of the information exchanged between the entity and Doral. This form contains information about:

(a) Who is the contract entity?

(b) Who is authorized to add or change the data being provided or received or the users authorized to access the data?

(c) Who will be actually submitting the data, if different from the contracted entity?

(d) What type of data will be accessible to the entity (e.g., or claims files, electronic remittance advice data, eligibility inquiry, etc.)?

(e) How the data exchange will occur (e.g., FTP via VPN, Internet Site, or secure email)?

(f) Will establish entity's User credentials, passwords, and sender IDs for reference in the control segments of the transaction guide(s)?

(g) Which transactions will generate a functional acknowledgement from the entity?

Section 2.03 Doral User Security Agreement

The Doral User Security Agreement, outlines the responsibilities associated with access to Doral data. All users are expected to and will be required to comply with all Federal, State and laws regarding data confidentiality, privacy, security, and user access.

Article III TECHNICAL INTERCHANGE

Section 3.01 Doral Communications Requirements

Doral will maintain various methods of obtaining EDI information with its providers. These methods will include Doral's Secure Web Server, FTP, 3.5" diskette, Compact Disc (CD), and Bulletin Board System. The preferred method of facilitating EDI exchange is via Doral's Secure Web Server. Outgoing transmissions, including all response transactions and functional acknowledgements will be available ONLY through Doral's Secure Web server or FTP with data encryption.

Section 3.02 File Encryption Procedures

Encryption is handled automatically as part of SSL (Secured Socket Layer) Web session created upon login to the Doral Secure Web Server. Data that pass through the SSL session are encrypted using a 128-bit algorithm and managed via The VeriSign $_{tm}$ Secure Site Program.

Section 3.03 File and Directory Naming Conventions

The directory structure on the Web server is designed to provide logical access to all files, ease troubleshooting searches, and simplify security for account set ups and maintenance. Doral is developing final naming conventions.

Individual file naming standards are also designed to provide ease in identifying a file and in troubleshooting searches.

Section 3.04 HIPAA Requirements

HIPAA standards are specified in the Implementation Guide (IG) for each transaction set and any authorized addenda. The guides include:

(a) Format and contents of interchanges and functional groups

(b) Format and contents of the header, detail and trailer segments specific to the transaction set

(c) Code sets and values authorized for use in the transaction set

(d) Allowed exceptions to specific transaction set requirements

Section 3.05 Multiple Transactions Within a File

Doral cannot allow multiple transaction types to be submitted within a single file submission. While the X12 standards do support the handling of multiple transaction set types such as an 837D and 276 to be submitted within a single file, Doral will not support transaction bundling within a file. Transaction sets must be sent separately with uniform naming conventions.

Section 3.06 Size of Transmissions/Batches

Fee-For-Service transmission sizes are limited based upon the number of Segments/Records allowed by HIPAA standards. HIPAA standards for the maximum file size of each transaction set are specified in the appropriate Implementation Guide or its authorized addenda. For 837 dental transactions, Doral is imposing a submission limit of 50,000 claim transactions per submission.

Section 3.07 Complete Transmission Check

All transactions are checked to ensure that the transmission is complete. The transaction header and footer must balance before a transaction file is processed.

Section 3.08 Balancing Data Elements

Doral will utilize any balancing requirements that can be derived from the transaction implementation guides. All financial amount fields must be balanced at all levels available within the transaction set. The number of transactions in the header and footer must equal and be the same as the number of transactions in the file.

Article IV ACKNOWLEDGMENT PROCESSES

Section 4.01 Overview of Acknowledgment Processes

Acknowledgment transactions let the sender know that the receiver received their transactions and that the transactions were accepted with no errors, accepted with errors, or rejected. The two types of Acknowledgment Transactions available are the:

(a) Interchange (TA1) Acknowledgment

(b) Functional Acknowledgment Transaction Set (997)

Section 4.02 Doral Requirements

(a) Doral plans on using the 997 transaction to acknowledge all transmission files.

(b) A provider may elect to send Doral an acknowledgement on any transmission files. These acknowledgements should be listed on the EDI Exchange Form.

Section 4.03 997 Functional Acknowledgment Transaction Sets

The 997 Functional Acknowledgment Transaction (997 Transaction) is designed to check each functional group in an interchange for data and syntax errors and send the results back to the sending trading partner. The 997 Transaction can accept or reject records at the functional group, transaction set, segment or data element level. The HIPAA statute and current implementation guides do not mandate the use of the 997 Transaction but recommend its usage. Characteristics of the 997 Transaction include:

(a) One 997 Transaction corresponds to one functional group in the interchange.

(b) 997 Transactions are transaction sets and thus are included in the interchange control structure (envelopes) for transmission.

(c) Many commercially available translators can automatically reconcile the 997 Transaction back to the previously sent functional group. This process allows the sending trading partner to identify any transaction sets that have not been acknowledged by the receiving trading partner.

(d) 997 Transactions should not be used to acknowledge the receipt of other 997 Transactions. Details on the format and syntax of the 997 Transaction can be found in Appendix B of each Transaction Set's Standard Implementation Guide.

Section 4.04 Rejected Transmissions and Transactions

The process for handling rejected transactions and transmissions will vary based on the error(s) causing the rejection.

(a) Interchanges or functional groups may be completely rejected for IG format violations.

(b) Individual records or transaction sets within a functional group/interchange will be rejected only in Fee-For-Service Claims files.

Numerous edits will be performed on each transaction processed. Each of these edits has a severity level associated with it that in conjunction with the number of errors will determine accept/reject status.

CONTROL SEGMENT DEFINITIONS FOR DORAL DENTAL SERVICES

X12N EDI Control Segments
ISA – Interchange Control Header Segment IEA – Interchange Control Trailer Segment GS – Functional Group Header Segment GE – Functional Group Trailer Segment TA1 – Interchange Acknowledgment Segment

ISA - Interchange Control Header Segment

Reference	Definition	Values
ISA01	Authorization Information Qualifier	00
ISA02	Authorization Information	[space fill]
ISA03	Security Information Qualifier	00
ISA04	Security Information	[space fill]
ISA05	Interchange ID Qualifier	ZZ
ISA06	Interchange Sender ID	[Doral-assigned 13 digit Trading Partner ID]
ISA07	Interchange ID Qualifier	ZZ
ISA08	Interchange Receiver ID	DDS391933153
ISA09	Interchange Date	The date format is YYMMDD
ISA10	Interchange Time	The time format is HHMM
ISA11	Interchange Control Standards Identifier	U
ISA12	Interchange Control Version Number	00401
ISA13	Interchange Control Number	Must be identical to the interchange trailer IEA02
ISA14	Acknowledgment Request	1
ISA15	Usage Indicator	T= Test Data P = Production Data
ISA16	Component Element Separator	**:** (Colon)

IEA - Interchange Control Trailer

Reference	Definition	Values
IEA01	Number of included Functional Groups	Number of included Functional Groups
IEA02	Interchange Control Number	Must be identical to the value in ISA13

GS – Functional Group Header

Reference	Definition	Values
GS01	Functional Identifier Code	HC = Health Care Claim (837) BE = Benefit Enrollment and Maintenance (834) HB = Eligibility Coverage or Benefit Information (270) HR = Health Care Claim Status Request (276) HI = Health Care Services Review Information (278)
GS02	Application Sender's Code	Must be identical to the value in ISA06
GS03	Application Receiver's Code	DDS391933153
GS04	Date	The date format is CCYYMMDD
GS05	Time	The time format is HHMM
GS06	Group Control Number	Assigned and maintained by the sender
GS07	Responsible Agency Code	X
GS08	Version/Release/Industry Identifier Code	004010X097A1 (Addenda Versions must be used)

GE – Functional Group Trailer

Reference	Definition	Values
GE01	Number of Transaction Sets Included	Number of Transaction Sets Included
GE02	Group Control Number	Must be identical to the value in GS06

Preferred Delimiters for Doral Dental EDI Transaction

Definition	ASCII	Decimal	Hexadecimal
Segment Separator	~	126	7E
Element Separator	*	42	2A
Compound Element Separator	:	58	3A

SEGMENT DEFINITIONS

ISA - Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

IEA - Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

GS – Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

GE – Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

ST – Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

SE – Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

INTRODUCTION TO THE 837 DENTAL HEALTHCARE CLAIMS TRANSACTION

The 837 transactions under HIPAA is the standard for electronic exchange of information between two parties to carry out financial activities related to a health care claim. The health care claim or equivalent encounter information transaction is the transmission of either of the following:

- A request to obtain payment, and the necessary accompanying information from a health care provider to a health plan, for health care.

- If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purpose of reporting health care.

The 837 Health Care Claim transaction set can be used to submit health care claim billing information, encounter information, or both. It can be sent from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits are required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists and pharmacies and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance benefit. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

This document consists of situational fields for the following transaction type that are required for processing Doral Dental Services Medicaid Dental claims; however, this document is not the complete EDI transaction format. This companion guide is based on the following transaction implementation guide. The full guide can be obtained from the Washington Publishing Company via their web site at www.wpc-edi.com/hipaa/HIPAA_40.asp.

Dental Transaction **ASC X12N 837(004010X097A1) October 2002**

FIELD DEFINITION

COLUMN

A The name of the loop as documented in the appropriate 837 Implementation Guide.

B A loop ID number used to identify a group of segments that are collectively repeated in a serial fashion up to a specified maximum number of times as documented in the appropriate 837 Implementation Guide.

C The field position number and segment number as specified in the appropriate 837 Implementation Guide.

D The data element name and page number as indicated in the appropriate 837 HIPAA Implementation Guide.

E The Values and Comments further describe the appropriate 837 Implementation Guide field data that Doral Dental will accept for processing a claim.

F Corresponding ADA Claim Form Reference (2002 Version J515) where applicable.

Loop Name	Loop- ID	837 Field Position & Segment	837 Data Element Name & Page Number from Imp Guide	Valid Values & Comments	ADA Dental Claim Form Mapping Location
A	B	C	D	E	F
Beginning of Hierarchical Transaction		010-BHT02	Transaction Set Purpose Code Pg 55	**'00'** Original	
Beginning of Hierarchical Transaction		010-BHT06	Transaction Type Code Pg 56	**'CH'** Chargeable	
Submitter Name	1000A	020-NM109	Identification Code Pg 61	[Doral-assigned 13 digit Trading Partner ID]	
Submitter Name	1000A	045-PER03	Communication Number Qualifier Pg 64	**'TE'** Telephone	
Receiver Name	1000B	020-NM103	Name Last or Organization Name Pg 67	**DORAL DENTAL SERVICES**	
Receiver Name	1000B	020-NM109	Identification Code Pg 67	**DDS391933153**	

The EDI formatting location of Pay-To, Billing, Rendering and Referring Provider Information is dependant upon the situation being billed. Below are the circumstances and EDI billing locations of this information.

Rendering Provider Location

Alternate Location 1:
If the Rendering Provider is not the same as the Pay-To Provider
Page 196 Loop 2310B

Loop Name	Loop- ID	837 Field Position & Segment	837 Data Element Name & Page Number from Implementation Guide	Valid Values & Comments	ADA Dental Claim Form Mapping Location
A	B	C	D	E	F
Rendering Provider Name	2310B	250-NM102	Entity Type Qualifier Pg 196	**'1'** - Person	
Rendering Provider Name	2310B	250-NM108	Identification Code Qualifier Pg 197	**'34'** – Social Security Number	

Alternate Location 2:
If the Rendering Provider is the same as the Billing and/or Pay-To Provider
And the Billing or Pay-To is not a group
Page 79 Loop 2000A

Billing/Pay-To Provider Hierarchical Level	2000A	003-PRV01	Provider Code Pg 12/Addenda	**'BI'** – If same as Billing Provider	

Pay-To Provider Location

Alternate Location 1:
If the Pay-To Provider is the same as the Billing Provider
Page 84 Loop 2010AA

Billing Provider Name	2010AA	035-REF01	Reference Identification Qualifier Pg 84	**'1D'** – Medicaid Provider Number	

Alternate Location 2:
If the Pay-To Provider is not the same as the Billing Provider
Page 88 Loop 2010AB

Pay-To Provider Name	2010AB	035-REF01	Reference Identification Qualifier Pg 95	**'1D'** – Medicaid Provider Number	

Billing Provider Location

Page 84 Loop 2010AA

Loop Name	Loop- ID	837 Field Position & Segment	837 Data Element Name & Page Number from Implementation Guide	Valid Values &Comments	ADA Dental Claim Form Mapping Location
A	B	C	D	E	F
Subscriber Hierarchical Level	2000B	001-HL04	Hierarchical Level Pg 97	**'0'** – No subordinate HL Segment in the Hierarchical Structure	
Subscriber Hierarchical Level	2000B	005-SBR01	Payer Responsibility Sequence Number Code Pg 99	**'T'** - Tertiary	
Subscriber Hierarchical Level	2000B	005-SBR09	Claim Filing Indicator Code Pg 102	**'MC'** - Medicaid	
Subscriber Name	2010BA	015-NM102	Entity Type Qualifier Pg 104	**'1'** Person	
Subscriber Name	2010BA	015-NM108	Identification Code Qualifier Pg 105	**'MI'** – Member Identification Number	
Subscriber Name	2010BA	015-NM109	Identification Code Pg 106	**PRIMARY IDENTIFICATION NUMBER**	**15**
Payer Name	2010BB	015-NM103	Name Last or Organization Name Pg 118	**DORAL DENTAL SERVICES**	**3**
Payer Name	2010BB	015-NM108	Identification Code Qualifier	**'PI'** – Payer Identification	

Loop Name	Loop- ID	837 Field Position & Segment	837 Data Element Name & Page Number from Implementation Guide	Valid Values &Comments	ADA Dental Claim Form Mapping Location
A	B	C	D	E	F
			Pg 118		
Payer Name	2010BB	015-NM109	Identification Code Pg 118	**DORAL DENTAL SERVICES**	**3**
Claim Information	2300	130-CLM11-1	Related Causes Code Pg 153	Reference Imp. Guide For Valid Values.	
Claim Information	2300	130-CLM12	Special Program Code Pg 155	**'01'** EPSDT	**1**
Referral Identification	2300	180-REF02	Reference Identification Referral Number Pg 182	Enter Provided Prior Authorization Number	**2**
Other Subscriber Information	2320	300-AMT02	Monetary Amount Payer Paid Amount Pg 220	Other Insurance paid Amount	
Tooth Information	2400	382-TOO02	Industry Code Tooth Number Pg 272	Tooth Number	**27**
Tooth Information	2400	382-TOO03 TOO03-1	Tooth Surface Tooth Surface Code Pg 272	Reference Imp. Guide For Valid Values.	**28**

Loop Name	Loop- ID	837 Field Position & Segment	837 Data Element Name & Page Number from Implementation Guide	Valid Values &Comments	ADA Dental Claim Form Mapping Location
A	B	C	D	E	F
Date of Service	2400	455-DTP03	Date Time Period Service Date Pg 274		

APPENDIX B

Covered Benefits (See Exhibits A and B)

This section identifies covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations for ***Smiles for Children*** members under age 21. There is a very limited adult dental benefit for the ***Smiles for Children*** members 21 and over, which is administered by Doral and described in Exhibit B. **Providers with benefit questions should contact Doral's Customer Service Department directly at:**

888.912.3456

Doral recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by "AS through TS" for primary teeth and tooth numbers "51" to "82" for permanent teeth. These codes must be referenced in the patient's file for record retention and review. **All dental services performed must be recorded in the patient record, which must be available as required by your Participating Provider Agreement.**

The Doral claim system can only recognize dental services described using the current American Dental Association CDT code list or those as defined as a Covered Benefit. All other service codes not contained in the following tables will be rejected when submitted for payment. A complete, copy of the CDT book can be purchased from the American Dental Association at the following address:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
800.947.4746

Furthermore, Doral subscribes to the definition of services performed as described in the CDT manual.

The benefit tables (Exhibits A & B) are all inclusive for covered services. Each category of service is contained in a separate table and lists:

1. the ADA approved service code to submit when billing,
2. brief description of the covered service,
3. any age limits imposed on coverage,
4. a description of documentation, in addition to a completed ADA claim form, that must be submitted when a claim or request for prior authorization is submitted,
5. an indicator of whether or not the service is subject to prior authorization, pre-payment review, or any other applicable benefit limitations.

Exhibit A: Benefits Covered (Ages 0 - 20)

Diagnostic services include the oral examination, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if Doral determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.

Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis.

Doral utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

All radiographs must be of good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Substandard radiographs will not be reimbursed for, or if already paid for, Doral will recoup the funds previously paid.

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation	0 - 20		No	One per 6 months per patient per dentist or dental group. Only one exam (D0120 or D0150) every 6 months.	
D0140	limited oral evaluation - problem focused	0 - 20		No	Limited examinations (D0140) are not reimbursable on the same day as codes D0150 and D9310.	

Exhibit A: Benefits Covered (Ages 0 - 20)

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0150	comprehensive oral evaluation - new or established patient	0 - 20		No	One comprehensive exam per patient per dentist or dental group. Only one exam (D0120 or D0150) every 6 months per patient per dentist or dental group.	
D0210	intraoral - complete series (including bitewings)	0 - 20		No	One complete series per 36 months per patient per dentist or dental group. Either a D0210 or D0330.	
D0220	intraoral - periapical first film	0 - 20		No		
D0230	intraoral - periapical each additional film	0 - 20		No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0240	intraoral - occlusal film	0 - 20		No	Two per 12 months.	
D0250	extraoral - first film	0 - 20		No		
D0260	extraoral - each additional film	0 - 20		No		
D0270	bitewing - single film	0 - 20		No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0272	bitewings - two films	0 - 20		No	One (1) per 12 months per patient per dentist or dental group. (D0272 or D0274).	
D0274	bitewings - four films	0 - 20		No	One (1) per 12 months per patient per dentist or dental group. (D0272 or D0274).	
D0330	panoramic film	0 - 20		No	Either a D0210 or a D0330 per 36 months patient per dentist or dental group.	
D0340	cephalometric film	0 - 20		No	Non-orthodontic procedures.	

Exhibit A: Benefits Covered (Ages 0 - 20)

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0470	diagnostic casts	0 - 20		No		

Sealants may be placed on the occlusal or occlusal-buccal surfaces of lower molars or occlusal or occlusal-lingual surfaces of upper molars once per tooth, per lifetime.

Space maintainers are a covered service when medically indicated due to the premature loss of posterior primary tooth. A lower lingual holding arch placed where there is not premature loss of the primary molar is considered a transitional orthodontic appliance and not covered by this Plan.

The application of topical fluoride treatment is allowed for Members up to age 21 once every 6 months when provided in conjunction with a prophylaxis. Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment.

BILLING AND REIMBURSEMENT FOR SPACE MAINTAINERS SHALL BE BASED ON THE CEMENTATION DATE.

Preventive						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	13 - 20		No	Includes minor scaling procedures. One (1) per 6 months per patient per dentist or dental group.	
D1120	prophylaxis - child	0 - 12		No	One (1) per 6 months per patient per dentist or dental group.	
D1203	topical application of fluoride (prophylaxis not included) - child	0 - 12		No	One (1) per 6 months per patient per dentist or dental group.	

Exhibit A: Benefits Covered (Ages 0 - 20)

Preventive						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1204	topical application of fluoride (prophylaxis not included) - adult	13 - 20		No	One (1) per 6 months per patient per dentist or dental group.	
D1351	sealant - per tooth	5 - 20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	Once per lifetime. Per tooth. Sealants will not be covered when placed over restorations. Teeth must be caries free. Includes buccal surfaces of mandibular molars and lingual surfaces of maxillary molars.	
D1510	space maintainer - fixed - unilateral	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	No	One per quad per 24 months.	Claim should indicate the missing tooth number(s).
D1515	space maintainer - fixed - biilateral	0 - 20	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No	One per arch per 24 months.	Claim should indicate the missing tooth number(s).

Exhibit A: Benefits Covered (Ages 0 - 20)

Preventive						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1520	space maintainer - removable - unilateral	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	No	One per quad per 24 months.	Claim should indicate the missing tooth number(s).
D1525	space maintainer - removable - biilateral	0 - 20	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No	One per arch per 24 months.	Claim should indicate the missing tooth number(s).
D1550	re-cementation space maintainer	0 - 20		No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least twelve months, unless there is recurrent decay or material failure. Payment will be made for only one single surface restoration per tooth surface. For example, two separate occlusal (O) restorations on the same tooth are to be billed as one occlusal restoration. However, for example it is permissible to bill for multiple, but separate restorations involving the same tooth surface, such as a mesial-facial (MF) and a distal-facial (DF) restoration on the same anterior tooth.

The acid etching procedure is considered part of the restoration and is not billed as a separate procedure.

Local anesthetic is included in the restorative service or surgical fee and is not separately reimbursed.

A sedative restoration is considered a temporary restoration only and not a base under a restoration.

Bases, copalite, or calcium hydroxide liners placed under a restoration are considered part of the restorations and are not billable as separate procedures.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Restorative pins are reimbursed on a per tooth basis, regardless of the number of pins placed.

Only full labial veneers porcelain (lab) are a covered service.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	amalgam - one surface, primary or permanent	0 - 20	Teeth 1 through 32, A through T	No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2150	amalgam - two surfaces, primary or permanent	0 - 20	Teeth 1 through 32, A through T	No		
D2160	amalgam - three surfaces, primary or permanent	0 - 20	Teeth 1 through 32, A through T	No		
D2161	amalgam - four or more surfaces, primary or permanent	0 - 20	Teeth 1 through 32, A through T	No		
D2330	resin-based composite - one surface, anterior	0 - 20	Teeth 6 - 11, 22 - 27, C - H, M - R	No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2331	resin-based composite - two surfaces, anterior	0 - 20	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2332	resin-based composite - three surfaces, anterior	0 - 20	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2335	resin-based composite - four surfaces, anterior	0 - 20	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2390	resin-based composite crown - anterior	0 - 20	Teeth 6 - 11, 22 - 27, C - H, M - R	No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2391	resin-based composite - one surface, posterior	0 - 20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I, J, K, L, S, T	No		
D2392	resin-based composite - two surfaces posterior	0 - 20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I, J, K, L, S, T	No		
D2393	resin-based composite - three surfaces, posterior	0 - 20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I, J, K, L, S, T	No		
D2394	resin-based composite - four or more surfaces, posterior	0 - 20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I, J, K, L, S, T	No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2710	crown - resin-based composite (indirect)	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs with claim for pre-payment review.
D2721	crown - resin based with predominantly base metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs with claim for pre-payment review.
D2722	crown - resin with noble metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs with claim for pre-payment review.
D2751	crown - porcelain fused to predominantly base metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs with claim for pre-payment review.

Exhibit A: Benefits Covered (Ages 0 - 20)

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2752	crown - porcelain fused to noble metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs with claim for pre-payment review.
D2791	crown - full cast predominantly base metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs with claim for pre-payment review.
D2792	crown - full cast noble metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs with claim for pre-payment review.
D2794	crown - titanium	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs with claim for pre-payment review.

Exhibit A: Benefits Covered (Ages 0 - 20)

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2915	recement cast or prefabricated post and core	0 - 20	Teeth 1 through 32	No		
D2920	recement crown	0 - 20	Teeth 1 through 32, A through T	No		
D2930	prefabricated stainless steel crown - primary tooth	0 - 20	Teeth A through T	No		
D2931	prefabricated stainless steel crown - permanent tooth	0 - 20	Teeth 1 through 32	No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2932	prefabricated resin crown	0 - 20	Teeth 1 through 32, A through T	No		
D2933	prefabricated stainless steel crown with resin window	0 - 20	Teeth C - H, M - R	No		
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0 - 20	Teeth C - H, M - R	No		
D2940	sedative filling	0 - 20	Teeth 1 through 32, A through T	No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2950	core buildup, including any pins	0 - 20	Teeth 1 through 32	No		
D2951	pin retention - per tooth, in addidtion to restoration	0 - 20	Teeth 1 through 32	No		
D2952	cast post and core in addition to crown	0 - 20	Teeth 1 through 32	No		
D2954	prefabricated post and core in addition to crown	0 - 20	Teeth 1 through 32	No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2962	labial veneer (porcelain laminate) - laboratory	0 - 20	Teeth 1 through 32	Yes	One per 60 months. Will be considered as an alternative to a full restoration for an endodontically treated tooth.	Pre-operative radiographs with claim for pre-payment review.

Exhibit A: Benefits Covered (Ages 0 - 20)

Payment for conventional root canal treatment is limited to treatment of permanent teeth.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet Doral's treatment standards, Doral can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after any post payment review by the Doral Consultants. A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment.

Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g. Sargenti filling material) is not covered.

Pulpotomies will be limited to primary teeth or permanent teeth with incomplete root development.

The fee for root canal therapy for permanent teeth includes diagnosis, extirpation treatment, temporary fillings, filling and obturation of root canals, and progress radiographs. A completed fill radiograph is also included.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3110	pulp cap - direct (excluding final restoration)	0 - 20	Teeth 1 through 32, A through T	No		
D3120	pulp cap - indirect (excluding final restoration)	0 - 20	Teeth 1 through 32, A through T	No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0 - 20	Teeth 1 through 32, A through T	No		Cannot be billed in conjuction with root canals (D3310, D3320 or D3330).
D3221	pulpal debridement - primary and permanent teeth	0 - 20	Teeth 1 through 32, A through T	No		
D3230	pulpal therapy - (resorbable filing) - anterior, primary tooth (excluding final restoration)	0 - 20	Teeth C - H, M - R	No		
D3240	pulpal therapy - (resorbable filing) - posterior, primary tooth (excluding final restoration)	0 - 20	Teeth A, B, I, J, K, L, S, T	No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3310	root canal - anterior (excluding final restoration)	0 - 20	Teeth 6 - 11, 22 - 27	No	One per lifetime per dentist.	
D3320	root canal - bicuspid (excluding final restoration)	0 - 20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One per lifetime per dentist.	
D3330	root canal - molar (excluding final restoration)	0 - 20	Teeth 1 - 3, 14 - 19, 30 - 32	No	One per lifetime per dentist.	
D3351	apexification/recalcification - initial visit (apical closure/clacific repair of perforations, root receptions, etc.)	0 - 20	Teeth 1 through 32	No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3352	apexification/recalcification - interim mediciation replacement (apical closure/clacific repair of perforations, root receptions, etc.)	0 - 20	Teeth 1 through 32	No	Limit three (3) treatments.	
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/clacific repair of perforations, root receptions, etc.)	0 - 20	Teeth 1 through 32	No	Once per lifetime per dentist.	
D3410	apicoectomy/periradicular surgery - anterior	0 - 20	Teeth 6 - 11, 22 - 27	Yes	Once per lifetime.	Pre-operative radiographs with claim for pre-payment review.
D3421	apicoectomy/periradicular surgery - bicuspid (first root)	0 - 20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	Once per lifetime.	Pre-operative radiographs with claim for pre-payment review.

Exhibit A: Benefits Covered (Ages 0 - 20)

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3425	apicoectomy/periradicular surgery - molar (first root)	0 - 20	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	Once per lifetime.	Pre-operative radiographs with claim for pre-payment review.
D3426	apicoectomy/periradicular surgery (each additonnal root)	0 - 20	Teeth 1 - 5, 12 - 21, 28 - 32	Yes		Pre-operative radiographs with claim for pre-payment review.
D3430	retrograde filling - per root	0 - 20	Teeth 1 through 32	Yes	Once per lifetime.	Pre-operative radiographs with claim for pre-payment review.

Exhibit A: Benefits Covered (Ages 0 - 20)

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy/gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	No	One per 24 months. Either D4210 or D4211. A minimum of four (4) affected teeth in the quadrant. Gingivectomies for the removal of hyperplastic tissue to reduce pocket depth. It should only be requested when non-surgical treatment does not achieve the desired results or when the patient is being treated with medications (i.e. dilantin) that result in such conditions.	Periodontal charting and pre-operative radiographs with claim for pre-payment review.
D4211	gingivectomy/gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	No	One per 24 months. Either D4210 or D4211. One (1) to three (3) affected teeth in the quadrant. Gingivectomies for the removal of hyperplastic tissue to reduce pocket depth. It should be only requested when non-surgical treatment does not achieve the desired results or when the patient is being treated with medications (ie dilantin) than result in such conditions.	Periodontal charting and pre-operative radiographs with claim for pre-payment review.
D4260	osseous surgery - four or more contiguous teeth or bounded teeth spaces per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes	One per 60 months. Either D4260 or D4261. A minimum of four (4) affected teeth in the quadrant.	Periodontal charting and pre-operative radiographs with claim for pre-payment review.
D4261	osseous surgery - one to three contiguous teeth or bounded teeth spaces per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes	One per 60 months. Either D4260 or D4261. One (1) to three (3) affected teeth in the quadrant.	Periodontal charting and pre-operative radiographs with claim for pre-payment review.

Exhibit A: Benefits Covered (Ages 0 - 20)

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4263	bone replacement graft - first site in quadrant	0 - 20	Teeth 1 through 32	Yes		Periodontal charting and pre-operative radiographs with claim for pre-payment review.
D4264	bone replacement graft - each additional site in quadrant	0 - 20	Teeth 1 through 32	Yes		Periodontal charting and pre-operative radiographs with claim for pre-payment review.
D4270	pedicle soft tissue graft procedure	0 - 20	Teeth 1 through 32	No		
D4271	free soft tissue graft procedure (including donor site surgery)	0 - 20	Teeth 1 through 32	No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4273	subepithelial connectivbe tissue graft procedures, per tooth	0 - 20	Teeth 1 through 32	No		
D4320	provisional splinting - intracoronal	0 - 20	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No		
D4321	provisional splinting - extracoronal	0 - 20	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No		
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	No	One per 24 months. Either D4341 or D4342. A minimum of four (4) affected teeth in the quadrant.	

Exhibit A: Benefits Covered (Ages 0 - 20)

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	No	One per 24 months. Either D4341 or D4342. One (1) to three (3) affected teeth in the quadrant. Check service limit.	
D4355	full mouth debridement to enable comprehensive evalation and diagnosis	0 - 20		No	4 quads per 12 months. Only covered when there is substantial gingival inflammation (gingivitis) in all four quadrants.	
D4910	periodontal maintenance	0 - 20		No	Any combination of D1110, D1120 and D4910 up to four (4) per 12 months. Covered following active treatment only (D4210, D4211, D4260, D4261, D4341, D4342).	

Provision for removable prostheses when masticatory function is impaired, or when existing prostheses is unserviceable and when evidence is submitted that indicates that the masticatory insufficiencies are likely to impair the general health of the member.

Authorization for partial dentures to replace posterior teeth will not be allowed if there are in each quadrant at least three (3) peridontially sound posterior teeth in fairly good position and occlusion with opposing dentition. For partial dentures, two or more posterior teeth must be missing in a quadrant or at least one posterior tooth in each quadrant of the same arch.

Authorization for cast partial dentures for anterior teeth generally will not be given unless two or more anterior teeth in the same arch are missing. A modified space maintainer is to be considered when only one anterior tooth is missing in an arch, Exceptions may be made on a per case basis.

Dentures will not be preauthorized when:

Dental history reveals that any or all dentures made in recent years have been unsatisfactory for reasons that are not remediable because of physiological or psychological reasons, or repair, relining or rebasing of the patient's present dentures will make them serviceable.

A preformed denture with teeth already mounted forming a denture module is not a covered service.

BILLING AND REIMBURSEMENT FOR CAST CROWNS AND POST & CORES OR REMOVABLE PROSTHETICS SHALL BE BASED ON THE CEMENTATION OR INSERTION DATE.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	0 - 20		No	One per 60 months.	

Exhibit A: Benefits Covered (Ages 0 - 20)

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5120	complete denture - mandibular	0 - 20		No	One per 60 months.	
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	0 - 20		Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	0 - 20		Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0 - 20		Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.

Exhibit A: Benefits Covered (Ages 0 - 20)

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0 - 20		Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D5225	maxillary partial denture - flexible base (including any conventional clasps, rests and teeth)	0 - 20		Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D5226	mandibular partial denture - flexible base (including any conventional clasps, rests and teeth)	0 - 20		Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D5281	removable unilateral partial denture - one piece cast metal (including clasps and teeth)	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.

Exhibit A: Benefits Covered (Ages 0 - 20)

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5410	adjust complete denture - maxillary	0 - 20		No	Not covered within 6 months of placement.	
D5411	adjust complete denture - mandibular	0 - 20		No	Not covered within 6 months of placement.	
D5421	adjust partial denture - maxillary	0 - 20		No	Not covered within 6 months of placement.	
D5422	adjustm partial denture - mandibular	0 - 20		No	Not covered within 6 months of placement.	

Exhibit A: Benefits Covered (Ages 0 - 20)

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5510	repair broken complete denture base	0 - 20	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No		
D5520	replace missing or broken teeth - complete denture (each tooth)	0 - 20	Teeth 1 through 32	No		
D5610	repair resin denture base	0 - 20	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No		
D5620	repair cast framework	0 - 20	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5630	repair or replace broken clasp	0 - 20		No		
D5640	replace broken teeth - per tooth	0 - 20	Teeth 1 through 32	No		
D5650	add tooth to existing partial denture	0 - 20	Teeth 1 through 32	No		
D5660	add clasp to existing partial denture	0 - 20		No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5730	reline complete maxillary denture (chairside)	0 - 20		No	One per 24 months. Not covered within 6 months of placement.	
D5731	reline complete mandibular denture (chairside)	0 - 20		No	One per 24 months. Not covered within 6 months of placement.	
D5740	reline maxillary partial denture (chairside)	0 - 20		No	One per 24 months. Not covered within 6 months of placement.	
D5741	reline mandibular partial denture (chairside)	0 - 20		No	One per 24 months. Not covered within 6 months of placement.	

Exhibit A: Benefits Covered (Ages 0 - 20)

Prosthodontics, removeable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5750	reline complete maxillary denture (laboratory)	0 - 20		No	One per 24 months. Not covered within 6 months of placement.	
D5751	reline complete mandibular denture (laboratory)	0 - 20		No	One per 24 months. Not covered within 6 months of placement.	
D5760	reline maxillary partial denture (laboratory)	0 - 20		No	One per 24 months. Not covered within 6 months of placement.	
D5761	reline mandibular partial denture (laboratory)	0 - 20		No	One per 24 months. Not covered within 6 months of placement.	

Exhibit A: Benefits Covered (Ages 0 - 20)

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5951	feeding aid	0 - 20		No		

Fixed prosthetics will only be covered under special circumstances when no other acceptable less expensive dental service will adequately accomplish the treatment objectives. Only bridges with cast retainers or noble or base metals will be covered.

Acid etch bonded bridges should be considered as less expensive alternate treatment if circumstances permit. Candidates for fixed prosthetics must have demonstrated very good to excellent oral hygiene and dental health awareness.

A fixed prosthetic will generally only be approved when it replaces a maximum of 2 missing anterior teeth or 1 posterior tooth. Exceptions can be made on a per case basis.

BILLING AND REIMBURSEMENT FOR CAST CROWNS AND POST & CORES OR ANY OTHER FIXED PROSTHETIC SHALL BE BASED UPON THE CEMENTATION DATE.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6205	pontic - indirect resin based composite	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6211	pontic - predominantly base metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.

Exhibit A: Benefits Covered (Ages 0 - 20)

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6212	pontic - cast noble metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6214	pontic - titanium	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6241	pontic - porcelain fused to predominantly base metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6242	pontic - porcelain fused to noble metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.

Exhibit A: Benefits Covered (Ages 0 - 20)

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6251	pontic - resin with predominantly base metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6252	pontic - resin with noble metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6545	retainer - cast metal for resin bonded fixed prosthesis	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6710	crown - indirect resin based composite	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.

Exhibit A: Benefits Covered (Ages 0 - 20)

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6721	crown - resin with predominantly base metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6722	crown - resin with noble metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6751	crown - porcelain fused to predominantly base metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6752	crown - porcelain fused to noble metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.

Exhibit A: Benefits Covered (Ages 0 - 20)

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6791	crown - full cast predominantly base metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6792	crown - full cast noble metal	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6794	crown - titanium	0 - 20	Teeth 1 through 32	Yes	One per 60 months.	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.
D6930	recement fixed partial denture	0 - 20	Teeth 1 through 32	No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6970	cast post and core in addition to fixed partial denture retainer	0 - 20	Teeth 1 through 32	No	One per 60 months.	
D6971	cast post as part of fixed partial denture retainer	0 - 20	Teeth 1 through 32	No	One per 60 months.	
D6972	prefabricated post and core in addition to fixed partial denture retainer	0 - 20	Teeth 1 through 32	No	One per 60 months.	
D6973	core build up for retainer; including any pins	0 - 20	Teeth 1 through 32	No	One per 60 months.	

Exhibit A: Benefits Covered (Ages 0 - 20)

Reimbursement includes local anesthesia and routine post-operative care.

The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Oral surgery procedures not listed in Exhibit A may be covered under the member's medical benefits through the Medicaid, FAMIS, or FAMIS Plus fee-for-service or managed care organization (MCO) program.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7111	extraction, coronal remnants - deciduous tooth	0 - 20	Teeth A through T, AS through TS (SN)	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0 - 20	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	No		
D7210	surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	0 - 20	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	No	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure.	

Exhibit A: Benefits Covered (Ages 0 - 20)

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7220	removal of impacted tooth - soft tissue	0 - 20	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	No	Removal of asymptomatic tooth not covered.	
D7230	removal of impacted tooth - partially bone	0 - 20	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	No	Removal of asymptomatic tooth not covered.	
D7240	removal of impacted tooth - completely bony	0 - 20	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	No	Removal of asymptomatic tooth not covered.	
D7241	removal of impacted tooth - completely bony, with unusual surgical complications	0 - 20	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	Yes	Unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required, aberrant tooth position, or unusual depth of impaction.	Pre-operative radiographs with claim for pre-payment review.

Exhibit A: Benefits Covered (Ages 0 - 20)

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7250	surgical removal of residual roots (cutting procedure)	0 - 20	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	No	Will not be paid to the dentists or group that previously removed the tooth. Removal of asymptomatic tooth not covered.	
D7260	oroantral fistula closure	0 - 20		No		
D7261	primary closure of a sinus perforation	0 - 20		No		
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0 - 20	Teeth 1 through 32	Yes		Narrative with claim.

Exhibit A: Benefits Covered (Ages 0 - 20)

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7280	surgical access of unerupted tooth	0 - 20	Teeth 1 through 32	Yes		Pre-operative radiographs and narrative with claim for pre-payment review.
D7282	mobilization of erupted or malpositioned tooth to aid eruption	0 - 20	Teeth 1 through 32	No		
D7283	placement of device to facilitate eruption of impacted tooth	0 - 20	Teeth 1 through 32	Yes	Will not be payable unless orthodontic treatment has been proposed or is in progress. Orthodontic approval is not required.	Pre-operative radiographs and narrative with claim for pre-payment review.
D7285	biopsy of oral tissue - hard (bone, tooth)	0 - 20		No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7286	biopsy of oral tissue - soft	0 - 20		No		
D7288	brush biopsy - transepithelial sample collection	0 - 20		No		
D7310	alveoloplasty in conjunction with extractions - per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	No	Once per lifetime. Either D7310 or D7311. Minimum of 3 extractions per quadrant.	
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	No	Once per lifetime. Either D7310 or D7311. 1 to 2 extractions per quadrant.	

Exhibit A: Benefits Covered (Ages 0 - 20)

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7320	alveoloplasty not in conjunction with extractions - per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	No	Once per lifetime. Either D7320 or D7321. No extractions performed in edentulous area.	Narrative of medical necessity should be maintained in patient records.
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0 - 20	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	No	Once per lifetime. Either D7320 or D7321. No extractions performed on edentulous area.	
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	0 - 20		Yes		Copy of pathology report with claim.
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	0 - 20		Yes		Copy of pathology report with claim.

Exhibit A: Benefits Covered (Ages 0 - 20)

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7471	removal of lateral exostosis - (maxilla or mandible)	0 - 20	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No		
D7472	removal of torus palatinus	0 - 20		No		
D7473	removal of torus mandibularis	0 - 20		No		
D7485	surgical reduction of osseous tuberosity	0 - 20		No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7510	incision and drainage of abscess - intraoral soft tissue	0 - 20		No	Either D7510 or D7511.	
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	0 - 20		No	Either D7510 or D7511.	
D7880	occlusal orthotic device, by report	0 - 20		No	Covered only for temporomandibular pain, dysfunction, or associated musculature.	
D7960	frenulectomy - (frenectomy or frenotomy) - separate procedure	0 - 20		No	Once per lifetime. Either a D7960 or D7963. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease. Midsagittal removal only.	

Exhibit A: Benefits Covered (Ages 0 - 20)

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7963	frenuloplasty	0 - 20		No	Once per lifetime. Either a D7960 or D7963. Excision of frenum with excision or repositioning of abervant muscle and z-plasty or other local flap closure.	
D7970	excision of hyperplastic tissue - per arch	0 - 20	Upper Arch 01 (UA) or Lower Arch 02 (LA)	No		
D7971	excision of pericoronal gingiva	0 - 20	Teeth 1 through 32	No		
D7972	surgical reduction of fibrous tuberosity	0 - 20		No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Medicaid Members age 20 and under may qualify for orthodontic care under the program. Members must have a severe, dysfunctional, handicapping malocclusion.

Since a case must be dysfunctional to be accepted for treatment, Members whose molars and bicuspids are in good occlusion seldom qualify. Crowding alone is not usually dysfunctional in spite of the aesthetic considerations.

Limited tooth guidance, if a covered benefit, will be authorized on a selective basis to help prevent the future necessity for full-banded treatment. All appliance adjustments are incidental and included in the allowance for the tooth guidance appliance. With the exception of situations involving gingival stripping or other non-reversible damage, appliances for minor tooth guidance (codes D8020 through D8040) will be approved when they are the only treatment necessary. If treatment is not definitive, the movement will only be covered as part of a comprehensive orthodontic treatment plan.

All orthodontic services require prior authorization by one of Doral's Dental Consultants. The Member should present with a fully erupted set of permanent teeth. At least 1/2 to 3/4 of the clinical crown should be exposed, unless the tooth is impacted or congenitally missing.

In evaluating requests for orthodontic coverage, medical necessity/handicapping criteria (Page A-3) are used as the first level review to determine coverage as applied to the permanent dentition. If the requested orthodontic treatment meets one of the listed criteria, Doral will approve the request for coverage as meeting medically necessary handicapping criteria. Please note, the orthodontic study models and all required documentation to support medical necessity should be submitted along with the Orthodontic Criteria Index Form. If the request does not meet any of the listed criteria, then Doral will proceed in evaluating the request by applying the Salzmann Malocclusion Severity Assessment (Pages A4 - A7).

The Salzmann Evaluation Criteria Index Form is also used as the basis for determining whether a Member qualifies for orthodontic treatment. A member must score a minimum of 25 points to qualify for coverage – points are not awarded for esthetics, therefore additional points for handicapping esthetics will not be considered as part of the determination.

For cases that do not meet the Salzmann criteria for approval, additional medical necessity information, such as speech, eating or emotional disorders, will be requested in the evaluation process.

Diagnostic study models (trimmed) with waxbites or OrthoCad electronic equivalent, and treatment plan must be submitted with the request for prior authorization of services. Treatment should not begin prior to receiving notification from Doral indicating coverage or non-coverage for the proposed treatment plan. Providers cannot bill prior to services being performed.

If the case is denied, the prior authorization will be returned to the Provider indicating that Doral will not cover the orthodontic treatment. However, an internal authorization will be issued for the payment of the pre-orthodontic visit (code D8660), which includes treatment plan, radiographs, and/or photos, records and diagnostic models, for full treatment cases only (D8080), at the Provider's contracted rate. This payment will be automatically generated for any case denied for full treatment.

General Billing Information for Orthodontics:

The start and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Member's mouth. The Member must be eligible on this date of service.

If a member becomes ineligible during treatment and before full payment is made, Doral will pay the balance of any remaining treatment up to the approved case rate. To receive the remaining balance for members that are ineligible but remain in treatment, providers must submit the claim using D8999 with the last service date the patient was eligible.

Exhibit A: Benefits Covered (Ages 0 - 20)

To guarantee proper and prompt payment of orthodontic cases, please follow the steps below:

Electronically file, fax or mail a copy of the completed ADA form with the date of service (banding date) filled in. Our fax number is 262. 241.7150.

Initial payments for orthodontics (code D8080) includes pre-orthodontic visit, radiographs, treatment plan, records, diagnostic models, initial banding, debanding, 1 set of retainers, and 12 months of retainer adjustments (If retainer fees are not separate).

Once Doral receives the banding date, the initial payment for code D8080 will be set to pay out. Providers must submit claims for 3 quarterly payments (Code D8670). The member must be eligible on the date of the claim .

The maximum case payment for orthodontic treatment will be 1 initial payment (D8080) and 3 quarterly periodic billed orthodontic treatments (D8670). Members may not be billed for broken, repaired, or replacement of brackets or wires. Payment for up to one set of lost/unrepairable retainers may be considered on a medically necessary basis.

Payment of records for cases that are denied will be made automatically. There is no need to submit for the records payment (Code D8660). Payment of records/exams (Code D8660) will NOT be paid prior to the case being reviewed by the consultant. Please do not submit separate claims for these procedures.

Please notify Doral should the Member discontinue treatment for any reason

Continuation of Treatment:

Doral Dental USA, LLC requires the following information for possible payment of continuation of care cases:

* Completed "Orthodontic Continuation of Care Form" - See Appendix A.
* Completed ADA claim form listing services to be rendered.
* A copy of Member's prior approval including the total approved case fee, banding fee, and periodic orthodontic treatment fees.
* If the member is private pay or transferring from a commercial insurance program: Original diagnostic models (or OrthoCad equivalent), radiographs (optional).

If the Member started treatment under commercial insurance or private pay or another State Medicaid program, we must receive the ORIGINAL diagnostic models (or OrthoCad), or radiographs (optional), banding date, and a detailed payment history.

It is the Provider’s and Member's responsibility to get the required information. Cases cannot be set-up for possible payment without complete information.

Orthodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required

Exhibit A: Benefits Covered (Ages 0 - 20)

Orthodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D8020	limited orthodontic treatment of the transitional dentition	0 - 20		Yes		Narrative of medical need.
D8030	limited orthodontic treatment of the adolescent dentition	0 - 20		Yes		Narrative of medical need.
D8040	limited orthodontic treatment of the adult dentition	0 - 20		Yes		Narrative of medical need.
D8080	comprehensive orthodontic treatment of the adolescent dentition	0 - 20		Yes		Study models (or OrthoCad equivalent). Panoramic or periapical radiographs. Cephalogram and/or photos are optional. PRIOR AUTHORIZATION IS REQUIRED.

Exhibit A: Benefits Covered (Ages 0 - 20)

Orthodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D8210	removable appliance therapy	0 - 20		No		
D8220	fixed appliance therapy	0 - 20		No		
D8670	periodic orthodontic treatment visit (as part of contract)	0 - 20		Yes	Maximum of 3 quarterly payments.	
D8999	unspecified orthodontic procedure, by report	0 - 20		Yes	Debanding by dentist other than dentist who initially banded case is one example.	Narrative of medical need.

Local anesthesia is considered part of the treatment procedure, and no additional payment will be made for it. Adjunctive general services include: IV sedation and emergency services provided for relief of dental pain.

Use of IV sedation and general anesthesia will be reviewed on a periodic basis. The service is not routinely used for the apprehensive dental patient. Medical necessity must be demonstrated. Use of nitrous oxide and conscious sedation will also be reviewed on a periodic basis, and patient medical records must include documentation of medical necessity.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Adjunctive General						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative (emergency) treatment of dental pain - minor procedure	0 - 20		No	Not allowed with any other services other than radiographs and emergency exam.	
D9220	deep sedation/general anesthesia - first 30 minutes	0 - 20		No		
D9221	deep sedation/general anesthesia - each additional 15 minutes	0 - 20		No	Maximum of 150 minutes (10 units).	

Exhibit A: Benefits Covered (Ages 0 - 20)

Adjunctive General						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9230	analgesia, anxiolysis, inhalation of nitrous oxide	0 - 20		No	The routine administration of inhalation analgesia or oral sedation is generally considered part of the treatment procedure, unless its use is documented in the patient record as necessary to complete treatment.	
D9241	intravenous conscious sedation/analgesia - first 30 minutes	0 - 20		No		
D9242	intravenous conscious sedation/analgesia - each additional 15 minutes	0 - 20		No	Maximum of 150 minutes (10 units).	
D9248	non-intravenous conscious sedation/analgesia	0 - 20		No	Must be documented as a medically necessity in the patient record.	

Exhibit A: Benefits Covered (Ages 0 - 20)

Adjunctive General						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9310	consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	0 - 20		No		
D9420	hospital call	0 - 20		No	Maximum of 3 (three) for the same stay.	
D9440	office visit - after regularly scheduled hours	0 - 20		No		
D9610	therapeutic drug injection, by report	0 - 20		No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Adjunctive General						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9630	other drugs and/or medications, by report	0 - 20		No	Not to be used for Nitrous Oxide or consious sedation.	
D9910	application of desensitizing medicament	0 - 20		No		
D9920	behavior management, by report	0 - 20		No		
D9930	treatment of complications (post surgical), by report	0 - 20		No		

Exhibit A: Benefits Covered (Ages 0 - 20)

Adjunctive General						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9999	unspecified adjunctive procedure, by report	0 - 20		Yes	For hospital operating room cases. Includes all workups and discharge summary. For other than hospital cases.	For hospital operating room cases, requires prior approval. For other than hospital cases, narrative of medical need with claim for prepayment review.

Exhibit B: Benefits Covered (Ages 21 And Older)

Coverage for adults, age 21 or older is limited to medically necessary oral surgery and associated diagnostic services. Oral surgery procedures not listed in Exhibit B may be covered under the member's medical benefits through the Medicaid, FAMIS, or FAMIS Plus fee-for-service or managed care organization (MCO) program. Contact Doral with any questions about coverage and reimbursement.

Diagnostic services include the oral examination, and selected radiographs, needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if Doral determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.

Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis.

Doral utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

All radiographs must be of good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Substandard radiographs will not be reimbursed for, or if already paid for, Doral will recoup the funds previously paid.

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0140	limited oral evaluation - problem focused	21 and older		No	Limited examinations (D0140) are not reimbursable on the same day as codes D0150 and D9310.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One comprehensive exam per patient per dentist or dental group. Not covered with D0140, D9310 same day.	

Exhibit B: Benefits Covered (Ages 21 And Older)

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0220	intraoral - periapical first film	21 and older		No		
D0230	intraoral - periapical each additional film	21 and older		No		
D0240	intraoral - occlusal film	21 and older		No		
D0250	extraoral - first film	21 and older		No		
D0260	extraoral - each additional film	21 and older		No		

Exhibit B: Benefits Covered (Ages 21 And Older)

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0330	panoramic film	21 and older		No	One per 36 months per patient per dentist or dental group.	

Exhibit B: Benefits Covered (Ages 21 And Older)

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy/gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	21 and older	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes	One per 24 months. Either D4210 or D4211. A minimum of four (4) affected teeth in the quadrant. Gingivectomies for the removal of hyperplastic tissue to reduce pocket depth. It should only be requested when the patient is being treated with medications (i.e. dilantin) that result in such conditions.	Periodontal charting and pre-operative radiographs for prepayment review.
D4211	gingivectomy/gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	21 and older	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes	One per 24 months. Either D4210 or D4211. One (1) to three (3) affected teeth in the quadrant. Gingivectomies for the removal of hyperplastic tissue to reduce pocket depth. It should be only requested when the patient is being treated with medications (i.e. dilantin) that result in such conditions.	Periodontal charting and pre-operative radiographs for prepayment review.

Exhibit B: Benefits Covered (Ages 21 And Older)

Extractions for adults, requires prepayment review and treatment must be considered medically necessary and complicating patient's general health and be documented as such by the dentist or medical provider.

Reimbursement includes local anesthesia and routine post-operative care.

The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Oral surgery procedures not listed in Exhibit B may be covered under the member's medical benefits through the Medicaid, FAMIS, or FAMIS Plus fee-for-service or managed care organization (MCO) program.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	Yes		Pre-operative radiographs and narrative of medical necessity with claim for prepayment review.
D7210	surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	21 and older	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	Yes	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure.	Pre-operative radiographs and narrative of medical necessity with claim for prepayment review.
D7220	removal of impacted tooth - soft tissue	21 and older	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	Yes	Removal of asymptomatic tooth not covered.	Pre-operative radiographs and narrative of medical necessity with claim for prepayment review.

Exhibit B: Benefits Covered (Ages 21 And Older)

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7230	removal of impacted tooth - partially bone	21 and older	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	Yes	Removal of asymptomatic tooth not covered.	Pre-operative radiographs and narrative of medical necessity with claim for prepayment review.
D7240	removal of impacted tooth - completely bony	21 and older	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	Yes	Removal of asymptomatic tooth not covered.	Pre-operative radiographs and narrative of medical necessity with claim for prepayment review.
D7241	removal of impacted tooth - completely bony, with unusual surgical complications	21 and older	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	Yes	Unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.	Pre-operative radiographs and narrative of medical necessity with claim for prepayment review.
D7250	surgical removal of residual roots (cutting procedure)	21 and older	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	Yes	Will not be paid to the dentists or group that previously removed the tooth. Removal of asymptomatic tooth not covered.	Pre-operative radiographs and narrative of medical necessity with claim for prepayment review.
D7260	oroantral fistula closure	21 and older		Yes		Pre-operative radiographs and narrative of medical necessity with claim for prepayment review.

Exhibit B: Benefits Covered (Ages 21 And Older)

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7261	primary closure of a sinus perforation	21 and older		Yes		Narrative of medical necessity with claim for prepayment review.
D7285	biopsy of oral tissue - hard (bone, tooth)	21 and older		Yes		Copy of pathology report with claim for prepayment review.
D7286	biopsy of oral tissue - soft	21 and older		Yes		Copy of pathology report with claim for prepayment review.
D7288	brush biopsy - transepithelial sample collection	21 and older		Yes		Copy of pathology report with claim for prepayment review.
D7310	alveoloplasty in conjunction with extractions - per quadrant	21 and older	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes	Once per lifetime. Either D7310 or D7311. Minimum of 3 extractions per quadrant.	Pre-operative radiographs and narrative of medical necessity on claim for prepayment review.

Exhibit B: Benefits Covered (Ages 21 And Older)

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes	Once per lifetime. Either D7310 or D7311. 1 to 2 extractions per quadrant.	Pre-operative radiographs and narrative of medical necessity on claim for prepayment review.
D7320	alveoloplasty not in conjunction with extractions - per quadrant	21 and older	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes	Once per lifetime. Either D7320 or D7321. No extractions performed in edentulous area.	Pre-operative radiographs and narrative of medical necessity on claim for prepayment review.
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Yes	Once per lifetime. Either D7320 or D7321. No extractions performed on edentulous area.	Pre-operative radiographs and narrative of medical necessity on claim for prepayment review.
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	21 and older		Yes		Copy of pathology report with claim and narrative of medical necessity on claim for prepayment review.
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	21 and older		Yes		Copy of pathology report with claim and narrative of medical necessity on claim for prepayment review.

Exhibit B: Benefits Covered (Ages 21 And Older)

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7471	removal of lateral exostosis - (maxilla or mandible)	21 and older	Upper Arch 01 (UA) or Lower Arch 02 (LA)	Yes		Narrative of medical necessity on claim for prepayment review.
D7472	removal of torus palatinus	21 and older		Yes		Narrative of medical necessity on claim for prepayment review.
D7473	removal of torus mandibularis	21 and older		Yes		Narrative of medical necessity on claim for prepayment review.
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older		Yes	Either D7510 or D7511.	Narrative of medical necessity on claim for prepayment review.
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		Yes	Either D7510 or D7511.	Narrative of medical necessity on claim for prepayment review.

Exhibit B: Benefits Covered (Ages 21 And Older)

Oral Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7880	occlusal orthotic device, by report	21 and older		Yes	Covered only for temporomandibular pain, dysfunction, or associated musculature.	Narrative of medical necessity on claim for prepayment review.

Exhibit B: Benefits Covered (Ages 21 And Older)

Local anesthesia is considered part of the treatment procedure, and no additional payment will be made for it. Adjunctive general services include: IV sedation and emergency services provided for relief of dental pain.

Use of IV sedation and general anesthesia will be reviewed on a periodic basis. The service is not routinely used for the apprehensive dental patient. Medical necessity must be demonstrated. Use of nitrous oxide and conscious sedation will also be reviewed on a periodic basis, and patient medical records must include documentation of medical necessity.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Adjunctive General						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9220	deep sedation/general anesthesia - first 30 minutes	21 and older		Yes		Narrative of medical necessity on claim for prepayment review.
D9221	deep sedation/general anesthesia - each additional 15 minutes	21 and older		Yes	Maximum of 150 minutes (10 units).	Narrative of medical necessity on claim for prepayment review.
D9230	analgesia, anxiolysis, inhalation of nitrous oxide	21 and older		Yes	The routine administration of inhalation analgesia or oral sedation is generally considered part of the treatment procedure, unless its use is documented in the patient record as necessary to complete treatment.	Narrative of medical necessity on claim for prepayment review.
D9241	intravenous conscious sedation/analgesia - first 30 minutes	21 and older		Yes		Narrative of medical necessity on claim for prepayment review.

Exhibit B: Benefits Covered (Ages 21 And Older)

Adjunctive General						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9242	intravenous conscious sedation/analgesia - each additional 15 minutes	21 and older		Yes	Maximum of 150 minutes (10 units).	Narrative of medical necessity on claim for prepayment review.
D9248	non-intravenous conscious sedation/analgesia	21 and older		Yes	Must be documented as a medically necessity in the patient record.	Narrative of medical necessity on claim for prepayment review.
D9310	consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	21 and older		No		
D9420	hospital call	21 and older		Yes	Maximum of 3 (three) for the same stay.	Narrative of medical necessity on claim for prepayment review.
D9610	therapeutic drug injection, by report	21 and older		Yes		Narrative of medical necessity on claim for prepayment review.

Exhibit B: Benefits Covered (Ages 21 And Older)

Adjunctive General						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9630	other drugs and/or medications, by report	21 and older		Yes	Not to be used for Nitrous Oxide, conscious sedation.	Narrative of medical necessity on claim for prepayment review.
D9930	treatment of complications (post surgical), by report	21 and older		Yes		Narrative of medical necessity on claim for prepayment review.
D9999	unspecified adjunctive procedure, by report	21 and older		Yes	For hospital operating room cases. Includes all workups and discharge summary. For other than hospital cases.	For hospital operating room cases, requires prior approval. For other than hospital cases, narrative of medical need with claim for prepayment review.